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87-1580

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1987

JOSEPH M. LOESCHNIG,

Petitioner,

vs.

CHRYSLER CREDIT CORPORATION, a corporation, CHRYSLER FINANCIAL CORPORATION, a corporation, CHRYSLER CORPORATION, a corporation,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTIONS PRESENTED

If a beneficiary participant of a health and welfare plan under the Employee Retirement Income Security Act complies with the eligibility requirements in the Summary Plan Description, can benefits be denied on the basis of claims administrators' rules that are not in the SPD and/or the plan itself?

PARTIES TO THE PROCEEDING

Joseph M. Loeschnig, an individual;

Chrysler Credit Corporation, a corporation;

Chrysler Financial Corporation, a corporation;

Chrysler Corporation, a corporation*

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* Chrysler Corporation is the parent corporation and wholly owns Chrysler Financial and Chrysler Credit.

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No. _____

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OCTOBER TERM 1988

JOSEPH M. LOESCHNIG,

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Respondents.

PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Petitioner, JOSEPH M. LOESCHNIG, respectfully prays that a Writ of Certiorari issue to review the Judgment and Opinion of the United States Court of Appeals for the Ninth Circuit entered in this proceeding on September 24, 1987, and to review the denial

of petitioner's Petition for Rehearing filed December 28, 1987.

OPINIONS BELOW

The Order denying petitioner's Petition for Rehearing in the Ninth Circuit Court of Appeals appears in the Appendix at H-49. The Opinion of the Ninth Circuit Court of Appeals is contained in its unpublished Memorandum in the Appendices at I51-64. The trial of this case took two and one-half days, from April 22 to April 24, 1986. The trial court's Memorandum of Intended Opinion was filed on May 1, 1986, and is present in Appendices J65-77. Notice of Entry of Judgment in the trial court on June 6, 1986, is at Appendix K-78.

JURISDICTIONAL STATEMENT

The Judgment of the Court of Appeals for the Ninth Circuit was entered on September 24, 1987. A timely Petition for Rehearing and Suggestion for Rehearing In Banc was denied by the Court of Appeals on December 28, 1987.

STATUTES AND REGULATIONS INVOLVED

Statutes and regulations involved in this case are as follows:

Sections 101, 102, 502, 503, and 510 of the Employee Retirement Income Security Act of 1974, as amended; 29 U.S.C. §§ 1001, 1022, 1104, 1132, 1133, and 1140 (1982); also, 29 C.F.R. 2560.503-1 published in the Federal Register on January 21, 1981. These statutory regulations are contained in Appendices A-1 thru G-48.

STATEMENT OF THE CASE

Petitioner, a 15-year employee of CHRYSLER CREDIT CORPORATION in Southern California, went on sick leave on November 18, 1981, because of a high blood pressure condition. At the time, he was working at the Long Beach, California, office of CHRYLSER CREDIT. He applied for disability compensation through his employment ERISA plan. The disability plan consisted of two tiers: One, a "Disability Absence Plan" administered by CHRYSLER FINANCIAL CORPORATION which provided for disability payments for 12 months, and, the other, a long-term disability payment plan which was integrated with the DAP and underwritten and administered by an insurance carrier. CHRYSLER FINANCIAL was at all times located in Troy, Michigan.

On November 2, 1982 (MR. LOESCHNIG had been on DAP benefits for 11-1/2 months),

CHRYSLER FINANCIAL mailed MR. LOESCHNIG a letter which stated that his disability benefits were being discontinued for failure to keep an appointment arranged by CHRYSLER CREDIT's Workers' Compensation Department. This letter was received by MR. LOESCHNIG on November 9, 1982 (Appendix L-80). On November 15, 1982, MR. LOESCHNIG filed a claims appeal (trial court Exhibit 38). Under letter date of November 15, 1982, CHRYSLER FINANCIAL advised MR. LOESCHNIG he was terminated from employment. On January 5, 1983, CHRYSLER FINANCIAL denied MR. LOESCHNIG his claims appeal (Appendix M-81).

Thereafter, MR. LOESCHNIG filed suit in the United States District Court for the Central District of California alleging he complied with all requirements of the Summary Plan Description, and that his benefits and job were wrongfully terminated. After a two-and-a-half-day court trial, the court found

that MR. LOESCHNIG's benefits were properly stopped because he failed to comply with a 30-day requirement for filing medical verifications of his disability and that his discharge from employment was valid.[1/]

MR. LOESCHNIG filed an appeal to the Ninth Circuit Court of Appeals in which he contended the trial court erred in its finding that he did not comply with a 30-day reporting requirement because the Summary Plan Description did not contain a 30-day reporting requirement, but a 90-day reporting requirement which he satisfied. MR. LOESCHNIG also contended that a host of ERISA and CFR

[1/] There is an anomaly concerning the reason or reasons for the denial of disability benefits. Chrysler Financial and its claims staff advised petitioner, as above noted, that his benefits were terminated because he failed to attend a workers' compensation examination. However, the trial court, affirmed by the Ninth District, found that the reason benefits were stopped was the failure of petitioner to abide by a 30-day requirement for filing medical reports.

regulations were violated by CHRYSLER FINANCIAL and that he was wrongfully discharged. The Appellate Court, in an unpublished Memorandum, found there was evidence to sustain the finding of the trial court as regards the 30-day reporting requirement, as well as the discharge. The Ninth Circuit Memorandum stated in part:

> "The record supports the District Court's finding that Loeschnig was required to submit proof of disability at thirty day intervals. Despite repeated reminders by Chrysler, Loeschnig failed to submit APSs or inform Chrysler of his whereabouts." ("APSs": Attending Physician's Statements.) (Appendix I-63)

Neither the trial court nor the Appellate Court pointed to or identified by exhibit number any documentary evidence on which they based the finding that there was a 30-day requirement with respect to forwarding written evidence of disability. The Summary Plan Description provided for a 90-day

requirement, plus a reasonable possible extension.[2/]

The trial court stated in its Memorandum that MR. LOESCHNIG did not on a single occasion contact any person associated with

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[2/] The Summary Plan Description is entered in the trial court as Exhibit 59, herein included as Appendices N-84 to N-163. Page 5 of the SPD stated in part (Appendix N-122):

"A. Eligibility.

To be eligible for Disability Absence Plan (DAP) you must

Be disabled because of personal illness or injury after you have one or more months of Continuous Service with Chrysler.

Be unable to perform all duties of your occupation.

Be under the continuous care of a legally qualified physician who certifies your disability.

Furnish written notice of claim and satisfactory proof of disability on a timely basis as explained on page 6."

The reporting requirements (Appendices N-129, N-130) were:

"1. Written Proof of Loss

You must furnish written proof of loss to your local Salary Administrator within 90 days after the termination of the period for which benefits are payable. Failure to furnish such proof within this

(cont. p. 9)

his employer. The Reporter's Transcript sets forth unrebutted testimony that MR. LOESCHNIG and his wife left the Los Angeles area for Las Vegas for a temporary stay, since his doctors advised him he should remove himself from the environment where he became ill. When in Las Vegas, on multiple occasions, MR. LOESCHNIG spoke with Business Representatives of the Las Vegas branch of CHRYSLER CREDIT (RT p. 307, ln. 17 - p. 308, ln. 8), and on January 27, he wrote a lengthy letter to Mr. Jones, his boss, in Long Beach (trial Exhibit 91).

2/ (cont.)

period does not invalidate or reduce a claim if it was not reasonably possible to do so, provided such proof is furnished as soon as reasonably possible and in no event except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Chrysler will have the right and opportunity to have you examined when and as often as it may reasonably require during pendency of your disability absence."

With respect to the Ninth Circuit's finding that "Loeschnig failed to submit APSs or inform Chrysler of his whereabouts," the record indicated that between December 15, 1981, and August 6, 1982, there were approximately 20 written communications to and from the LOESCHNIGS living in Las Vegas and CHRYLSER FINANCIAL in Troy, Michigan,[3/] in

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[3/] 12/15/81, APS, Loeschnig to Chrysler; 12/20/81, APS Chrysler to Loeschnig; 1/4/82, Exhibit 6, Mailogram, Chrysler to Loeschnig and telephone call, Mrs. Loeschnig to Chrysler; 1/8/82, Exhibit 7, Mailogram, Chrysler to Loeschnig re exam with Dr. Miller; 2/6/82, Exhibit 12, Chrysler to Loeschnig re results Dr. Miller exam; 3/82, Loeschnig to Chrysler, medical report; 5/6/82, APS from Loeschnig to Chrysler; 5/28/82, Exhibit 16, Chrysler to Loeschnig letter re Social Security; 6/8/82, Exhibit 17, Chrysler to Loeschnig, Mailogram re exam with Dr. Miller on 6/3/82; 6/82, Exhibit 18, Loeschnig to Chrysler re Social Security form; 6/14/82, Exhibit 19, Loeschnig to Chrysler re doctor's forms and bills; 6/24/82, Exhibit 21, Chrysler to Loeschnig re medical bills; 6/25/82, Exhibit 23, Mailogram, Chrysler to Loeschnig re exam Dr. McKinnon; 8/2/82, APS form, Loeschnig to Chrysler; 8/11/82, Exhibit 31, Chrysler to Loeschnig letter re long-term disability; 10/19/82, Exhibit 34, Chrysler to Loeschnig re Social Security; 10/82, response of Loeschnig to Chrysler re Social Security.

addition to the monthly checks CHRYSLER FINANCIAL mailed to MR. LOESCHNIG for 11 months. These included three Mailograms from CHRYSLER to MR. LOESCHNIG informing him of dates for physical examinations by CHRYSLER's consultants; on each occasion, MR. LOESCHNIG kept the appointment. Also, there were five APS forms mailed from MR. LOESCHNIG to CHRYSLER.[4/]

The Ninth Circuit Memorandum states that in February 1982, CHRYSLER FINANCIAL advised MR. LOESCHNIG he must furnish APSs (Attending Physician's Statements) every 30 days. The only written evidence that bears on the subject of this Ninth Circuit statement is Exhibit 12 in the trial court (herein Appendix

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[4/] Trial Exhibit 35 discloses APSs were forwarded to Mr. Loeschnig on 1/30/81, 5/14/82, 5/16/82, and 7/21/82. Completed APS forms in Chrysler Financial's file are dated 12/15/81, 12/21/81, March 1982, 5/6/82, and 8/2/82 (stamped as received by respondents on 8/6/82).

O-164). The latter is a letter of February 6, 1982, explaining the results of Dr. Miller's examination and states in part:

> "You can anticipate receiving and filing these supplementary reports at thirty (30) day intervals."

The Plan itself for the relevant period of MR. LOESCHNIG's claim (November 1981 - November 1982) was not offered into evidence by respondents. Respondents offered a Plan dated 2/7/83 (trial Exhibit 206) which was entered into evidence at the trial over petitioner's objection.

The only reference in the 2/7/83 Plan to a 30-day reporting requirement is as follows:

> "The Attending Physician's Statement ... is generally requested by the local Salary Administrator at thirty (30) day intervals ..."

During the period of November 30, 1981, to August 6, 1982, CHRYSLER FINANCIAL received nine medical reports which unanimously confirmed MR. LOESCHNIG's disability from his

regular work; some stated he should not return to work for CHRYSLER CREDIT.[5/]

[5/] The following medical reports were entered into evidence with the respective exhibit numbers:

11/30/81, Victor L. Gould, M.D. (Exhibit 1):

> "Mr. Joseph M. Loeschnig has been under my care for treatment from the 12th of July, 1979, until the present time ... He is suffering from malignant hypertension and post-cerebral vascular failure and will not be able to work due to this malignant condition.";

12/11/81, Attending Physician's Statement, by Victor L. Gould, M.D. (Exhibit 4), indicating petitioner unable to work due to malignant hypertension and post-cerebral vascular failure;

1/12/82, Victor L.Gould, M.D. (Exhibit 9):

> " ... I agree that continued stress from Chrysler type of occupation will surely end in a complete incapacity or possible stroke ...";

1/29/82, Russell L. Miller, M.D., Respondents' Consultant (Exhibit 11):

> "Joseph Loeschnig was examined on January 15, 1982 ...
>
> " ... His blood pressure was 180/100 ... I feel that Mr. Loeschnig is totally disabled from his present occupation.";

3/1/82, Victor Gould, M.D.(Exhibit 13):

> "Prognosis: Poor. Continued stress

(cont. p. 14)

The November 2, 1982, letter mailed to MR. LOESCHNIG in Las Vegas reads as follows:

5/ (cont.)

from Chrysler type of occupation will surely end in complete incapacity or possible stroke.";

5/6/82, Victor Gould, M.D. (Exhibit 14), indicating that petitioner was disabled from work, the termination date of disability was extended;

7/9/82, Harry L. McKinnon, Jr., M.D. (Also consultant Retained by Respondents) (Exhibit 25):

" ... His hypertension appears to be poorly controlled even with medication. ... Hypertensive vascular disease is without question aggravated and worsened by stressful situations, and it is on this basis that the recommendation has been made that he not return to his previous occupation. It is a value judgment with which I concur.

" ... I would have to judge that Mr. Loeschnig is probably indeed totally disabled at this time by virtue of his hypertensive vascular disease. ...";

7/22/82, Russell L. Miller, M.D. (Exhibit 28), where he indicated blood pressure medication was increased, blood pressure was 142/95, and stated:

"I feel that he could return to work in a lesser capacity not involving emotional stress ...";

(cont. p. 15)

"Your Disability Absence Plan benefits are being discontinued effective October 25, 1982, due to your failure to substantiate your continuing disability by not reporting for a scheduled physical examination.

"You are instructed to report for work to the Long Beach Office, Suite 318, 4201 Long Beach Boulevard, Long Beach, at your normal starting time on Monday, November 8, 1982." (Appendix L-80)

The "scheduled physical examination" was with an Orange County, California, doctor in connection with MR. LOESCHNIG's workers' compensation case. It was not requested nor arranged by respondents, nor had respondents advised MR. LOESCHNIG it was necessary for him to keep the Orange County examination in order to continue to receive his disability payments.[6/]

5/ (cont.)

8/2/82, Received by Respondents on 8/6/82, Victor Gould, M.D. (Exhibit 30), indicating petitioner continues to be disabled and termination of total disability was "unknown."

6/ These latter two statements are stipulated as true in the Pretrial Conference Order (CR 59, p. 6[g]).

CHRYSLER FINANCIAL sent Mailograms to MR. LOESCHNIG on three occasions requesting him to report for medical examinations and, in each, he was admonished that the failure to keep the appointment would result in suspension of benefits (trial Exhibits 7, 17, 23). MR. LOESCHNIG kept all of the appointments. Mr. Slywka, Claims Manager for CHRYSLER FINANCIAL, testified it was the responsibility of CHRYLSER FINANCIAL's Claims Department to originate the process of completing the Attending Physician's Statements (RT p. 50, lns. 19-23; p. 51, lns. 4-9). When these forms were mailed from his office, a note was made in the Activity Log; the last form mailed to MR. LOESCHNIG was on July 21, 1982 (RT p. 170, lns. 16-18; p. 170, ln. 25 - p. 171, ln. 2). The last APS returned was dated August 2, 1982, and received by CHRYSLER FINANCIAL on August 6, 1982 (see Footnote 4, supra, p. 11).

The letter of November 2, 1982, was received by MR. LOESCHNIG on November 9, 1982, because it was sent to a former address (RT p. 292, lns. 3-22). He was not informed by anyone that the request to be examined for his workers' compensation case had anything to do with the Disability Absence claim, and, in his mind, the Disability Absence claims and the workers' compensation claims were separate (RT p. 293, ln. 22 - p. 294, ln. 2). After receiving the letter of November 2, MR. LOESCHNIG went to Dr. Miller's office in Las Vegas and Dr. Miller gave him a note stating that because of his high blood pressure condition, he should not travel (RT p. 294, lns. 3-23). At the same time, Dr. Miller gave him the completed disability form for long-term disability, and he forwarded both of these documents to CHRYSLER FINANCIAL on November 9, 1982 (RT p. 295,

ln. 4 - p. 296, ln. 13, trial Exhibit 37).[7/]

At the trial level and in his appeal, MR. LOESCHNIG contended there was unrebutted evidence which demonstrated that respondents violated ERISA claims requirements. Some of these contentions were:

1. The letter of November 2, 1982, did not specify the true reason MR. LOESCHNIG's benefits were terminated (i.e., failure to submit medical reports every 30 days). Section 503 of the Act, 29 U.S.C. §1133(1), and 29 C.F.R. 2560.503-1(f) insist that a denial of benefits letter give "the specific reason or reasons for the denial as well as the specific reference to the plan provisions on which the denial is based."

[7/] Dr. Miller was Chrysler Financial's consultant. After being referred to him a second time by Chrysler, Mr. Loeschnig treated with him and gave him the long-term disability form to complete.

2. Claims Manager Slywka testified he knew MR. LOESCHNIG's counsel requested a copy of the report of his consultant, Dr. McKinnon, and he "didn't do anything in response to the request" (RT p. 93, lns. 5-13). In October 1982 when MR. LOESCHNIG was receiving disability payments, Mr. Slywka asked Mr. Colton, Personnel Manager of CHRYSLER FINANCIAL, about the requirements of terminating MR. LOESCHNIG's employment in Long Beach, California (RT p. 232, lns. 15-25). Mr. Slywka was the decision maker with respect to terminating MR. LOESCHNIG's disability payments. Mr. Colton also testified that Mr. Slywka had a role in terminating MR. LOESCHNIG's employment (RT p. 242, ln. 22 - p. 243, ln. 6). Mr. Slywka was assigned to respond to MR. LOESCHNIG's claims appeal. Section 503, U.S.C. §1133(2) requires a "full and fair" claims review as does C.F.R. 2560-503-1(g).

MR. LOESCHNIG contended in the trial and in his appeal that assigning claims appeals to Mr. Slywka to answer was not a "full and fair claims review."

3. Mr. Slywka's response to the claims appeal (trial Exhibit 41) did not mention anything about a 30-day reporting rule. Also, Mr. Slywka testified CHRYSLER FINANCIAL did not inform MR. LOESCHNIG of all the reasons his benefits were terminated (RT pp. 122-124). The notice and disclosure requirements with respect to claims appeals were violated, since these regulations require that specific reasons for the denial of benefits with reference to the pertinent Plan provisions be accurately transmitted to the beneficiary. 29 C.F.R. 2560.503-1(g) and U.S.C. § 1133(2).

4. The finding that there was a 30-day reporting requirement is contrary to Section 102(b) of the Act (since there is not

mentioned in the SPD a 30-day requirement), as this section of ERISA requires that the SPD "shall" contain information "regarding eligibility for participation and benefits."[8/]

Neither the trial court nor the Ninth Circuit commented upon these and other contentions of Petitioner concerning violations of ERISA claims statutes and regulations.

[8/] With respect to testimony concerning the premise that there was a 30-day reporting requirement, Mr. McCarter testified that "we" advised Mr. Loeschnig by "memorandum" that "we required these forms on 30-day intervals" (RT p. 171, lns. 21-23), but no such memorandum exists. Mr. McCarter probably had in mind his letter of February 6, 1982 (Exhibit 12, Appendix O-164) which stated in part, "You can anticipate receiving and filing these supplementary reports at thirty (30) day intervals." Mr. Slywka testified, "We advised Mr. Loeschnig that we required doctor's statements at 30-day intervals." (RT p. 127, lns. 7-10), but Mr. Slywka's statement is unsupported by any documentation, and he later testified, "We never directly communicated with Mr. Loeschnig during the entire 12-month period." (RT p. 133, lns. 3-4.)

REASONS FOR GRANTING THE WRIT

I

THE NINTH CIRCUIT'S DECISION TO BASE ELIGIBILITY FOR BENEFITS UNDER AN ERISA DISABILITY PLAN ON MATTERS NOT INCLUDED IN THE SUMMARY PLAN DESCRIPTION (i.e., 30-DAY REPORTING REQUIREMENT) CONFLICTS WITH THE RULINGS OF THE ELEVENTH AND EIGHTH CIRCUITS, AND OTHER DISTRICT COURTS.

In its Memorandum, the Ninth Circuit does not allude to the fact that there is not mentioned in the SPD any requirement of a 30-day reporting period to submit medical reports. Petitioner argued this point extensively in his Opening Brief, oral argument, and the Petition for Rehearing. It is plain that the SPD does not contain such a requirement. It is therefore assumed that the Ninth Circuit, in supporting the trial court's finding that MR. LOESCHNIG was properly denied benefits because he failed to conform to a 30-day requirement to file

medical reports, agrees with the trial court that fiduciaries to an ERISA disability plan may rely on proscriptions articulated outside the SPD in denying benefits.

The concept of going outside the SPD, even to the plan itself, to determine rules of eligibility for ERISA benefits is in conflict with the Eleventh Circuit case of McKnight v. Southern Life & Health Insurance Co., and Southern Life & Health Insurance Co. Revised Retirement Plan, 758 F.R.2d 1566 (1985). In the latter case, there was a dispute concerning eligibility of a beneficiary in an ERISA retirement plan. The beneficiary relied on the SPD to demonstrate her elibibility and the fiduciary opposed her on the ground that the Plan Administrator reasonably relied on evidentiary material in the plan itself. In this regard, the Eleventh Circuit Court Stated:

"Assuming that Southern Life's interpretation of the plan is correct, reasonable application of the sumamry provision does not support Southern Life's position. ERISA provides that the summary shall be an accurate and comprehensive document that reasonably apprises the employees of their rights under the plan."
McKnight, supra, 758 F.R.2d 1570.

The McKnight court further stated with respect to the issue of an inconsistency between the SPD and the plan itself:

"Although Southern Life submits that both the plan and summary are consistent, Southern Life asserts that if a conflict arose between the plan and the summary, the plan should prevail. Such an assertion defeats the purpose of the summary. It is of no effect to publish and distribute a plan summary booklet designed to simplify and explain a voluminous and complex document, and then proclaim that any inconsistency will be governed by the plan. Unfairness will flow to the employee for reasonably relying on the summary booklet."
McKnight, supra, 758 F.2d 1570.

Where plan documents provide for eligibility and disqualifications of benefits,

the Eighth Circuit, contrary to the Ninth, agrees that a determination of benefits cannot be based on pronouncements outside the terms of the plan:

> "Where the trustees impose a standard not required by the pension plan itself, this court has stated that such action 'would result in an unwarranted and an arbitrary construction of the Plan.' Maness v. Williams, supra, 513 F.2d at 1267." Maness v. Williams, 513 F.2d 1264 (8th Cir. 1975). Morgan v. Julius Mullins, Trustee, etc.,643 F.R.2d 1320, 1321 (1981, 8th Cir.)

The District court case of Kochendorfer v. Rockdale Sash & Trim Co. Profit Sharing Plan (1987, D.C.Ill.), 653 F.Supp. 612, is also inconsistent with the herein Ninth Circuit decision. Kochendorfer involved a dispute in which the plaintiff contended he was entitled to benefits based on a booklet he received from his employer. He did not receive a copy of the SPD and maintained that the booklet served the same purpose as the SPD of outlining the benefits to which

he was entitled. The defendant in the case agreed with the reasoning in the above-cited case of McKnight v. Southern Life & Health Insurance Co., 758 F.2d 1566 (11th Cir. 1985), to the effect that where there is a dispute as between an SPD and the plan itself, an individual has the right to rely on the SPD as opposed to the plan. The Kochendorfer court sought to define an SPD to determine whether the booklet could fit such a definition. In this regard, the court invoked the intent of Congress to demonstrate its position that an SPD must by law set forth certain requirements for obtaining or denying benefits, to wit:

> "The crucial information which any document must contain before it could be deemed a summary plan description includes an explanation of the benefits and circumstances which may disqualify a participant from securing benefits. S.Rep. 127, 93rd Con.2d Sess., reprinted in 1974 U.S. Code Cong. & Admins. News 4639, 4838, 4864."
> Kochendorfer, supra, 653 F.Supp. 615-616 (1987).

The question as to whether Mr. McCarter's letter of February 6, 1982, to MR. LOESCHNIG satisfied the requirements of the SPD or an amendment to the SPD was not addressed by the trial court nor the Ninth Circuit. The letter (Appendix O-164) has a general reference to the receipt of benefits in a single sentence, i.e., "You can anticipate receiving and filing these supplementary reports at thirty (30) day intervals." This statement is couched in option language and not in mandatory language which is used to formulate requirements to obtain benefits from an ERISA benefit plan, or as often seen, in insurance company policies. Such statement does not pretend to be an amendment to, nor does it refer in any manner to the SPD. More importantly, it does not comprise the elements of what is required in an SPD as related in the Kochendorfer case ("an explanation of the benefits and circumstances which may

disqualify a participant from securing benefits"). Kochendorfer, supra, 653 F.Supp. 615-661 (1987).

The terms "arbitrary and capricious" are used throughout the case law as well as in pleadings in all jurisdictions in connection with the administration of ERISA. It should therefore be a goal that when these expressions are used to describe the conduct of fiduciaries or others who administer or make decisions on ERISA benefits plans, that they signify the same or similar type of conduct. The decision in your petitioner's case is in conflict with at least the Eighth Circuit as regards the use of "arbitrary and capricious." In Wilken v. AT&T Technologies, Inc. (E.D. Missouri, 1984) 632 F.Supp. 772, 774. the court noted: "Trustees act aribtrarily when they impose a standard not required by the pension plan itself," citing as authority the case of Morgan v. Mullins,

supra, 643 F.2d 1320, and Maness v. Williams, supra, 513 F.2d 1264 (1975). The Ninth Circuit in this instance is not in sinc with the latter courts, as a premise on which it relies in affirming the trial court is based on a regulation which is not contained in the SPD or the plan itself, and hence it is a standard imposed on the SPD as well as the plan itself.

II

THE NINTH CIRCUIT'S DECISION IS VIOLATIVE OF THE BASIC TENETS OF ERISA STATUTES WHICH MANDATE THAT NOTICE AND DISCLOSURE REQUIREMENTS FOR ELIGIBILITY AND DENIAL OF BENEFITS TO BENEFICIARIES BE INCLUDED IN THE SUMMARY PLAN DESCRIPTION.

This Court has noted in the past that ERISA is a "comprehensive and reticulated statute" formulated with specific rules by Congress aimed at enhancing "the well-being

and security of millions of employees and their dependents," Nachman Corp. v. Pension Benefit Guarantee Corp., 44 U.S. 359, 361 (1980), and that "We are reluctant to 'fine-tune' an enforcement scheme crafted with such evident care as the one in ERISA." (Massachusetts Mutual Life Insurance Co. v. Russell, 473 U.S. 134 [1985].)

In 29 U.S.C. §1001(b), Congress sets forth that it is a policy of the Employee Retirement Income Security Act to protect beneficiary participants by "requiring the disclosure and reporting to participants and beneficiaries ... of information with respect ... (to the Act, and) by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans ..."

The Summary Plan Description is selected as the vehicle to provide the participant beneficiaries with as complete knowledge as

possible as well as information necessary to carry out the stated policy. With this concept in mind, Congress enacted Section 102(b) which, in part, states:

> "The plan description and summary plan description shall contain the following information: ... The plan's requirements, respecting eligibility for participation and benefits; ... circumstances which may result in disqualification, ineligibility, or denial or loss of benefits ..." Also, contained in 29 U.S.C. §1022(b)

The Department of Labor emphasizes the necessity for the content of the summary plan description to provide notice and disclose the reasons for disqualification or denial of benefits. In this regard, 29 C.F.R. 2520.102-3 provides:

> "Section 102 of the Act specifies information that must be included in the summary plan description; the following information shall be included in the summary plan description of both employee welfare benefit plans and employee pension benefit plans, except as stated as otherwise in paragraph (j) through (n):

"(1) For both pension and welfare benefit plans, a statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits that a particpant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by paragraph (j) and (k) of this section."

In the District court case of Zittrouer v. Uarco, Inc. Group Plan, 582 F.Supp. 1471 (1984) (Georgia), the defendant argued that an age restriction for hospital benefits in its Plan overruled the SPD which did not contain the age restriction. The court held to the contrary as it stated:

"This focus misses the point. By law defendant is required to include within the summary plan 'circumstances which may result in disqualification, ineligibility, or denial or loss of benefits ...'. 29 U.S.C. §1022(b). Defendant's failure to do so is at best gross negligence and at worst intentional deception through concealment or inaction. The fact that defendant's summary plan included the quoted disclaimer does not relieve defendant of the statutory requirement

of disclosure."
Zittrouer, supra, 582 F.Supp. 1475 (1984)

The key document required by law to apprise a beneficiary of his eligibility to receive benefits, namely, the SPD, did not, with reference to MR. LOESCHNIG, contain the "circumstances" which resulted in disqualifying or denying him benefits. There is no reference in CHRYSLER FINANCIAL's Summary Plan Description of a 30-day reporting requirement (Appendix O-163). As noted above, the only written evidence bearing on the question of notice to MR. LOESCHNIG of a 30-day reporting requirement is contained in the letter of February 6, 1982 (Appendix O-164). Ignoring petitioner's argument that the language in this letter does not amount to a "requirement," it is still obvious that MR. LOESCHNIG was denied benefits on the basis of a condition that did not appear in the Summary Plan Description.

Thus, we have a District court in the Eleventh District who assesses the failure to include in the SPD "circumstances which may result in disqualification and ineligibility" as gross negligence or deception, and another in the Ninth Circuit (supported by the Ninth Circuit Court of Appeals) which agrees that administrative regulations not included in the SPD are valid and enforceable.

III

REVERSAL OF THE NINTH CIRCUIT'S DECISION IS NECESSARY TO MAINTAIN THE INTEGRITY OF THE ACT WITH RESPECT TO THE RIGHTS OF BENEFICIARY PARTICIPANTS.

The legal remedies of beneficiary participants under ERISA are less in number and degree compared to the legal remedies they had before ERISA. They do not have the right to trial by jury, In re Vorpahl, 695 F.2d 318 (8th Cir., 1982); Calamia v. Spivey,

632 F.2d 1235 (5th Cir., 1980); Wardle v. Central States, 627 F.2d 820, 828-30 (7th Cir., 1980), cert. denied, 449 U.S. 112, 101 S.Ct. 922 (1981); they do not have a right to punitive or extra contractual damages, Massachusetts Mutual Life Insurance Co. v. Russell, supra, 473 U.S. 134 (1985); they do not have a right to attorney fees except by discretion of the court and it has been held that attaining success in litigation does not carry with it an award for attorney fees, McKnight v. Southern Life & Health Insuance Co., supra, 758 F.2d 1566, 1572 (11th Cir., 1985); also, the burden of proof to establish error on behalf of fiduciaries and obtain relief is greater than it was prior to ERISA.

> "Decisions by the trustee of an employee benefit plan will not be reversed by the courts unless they are arbitrary, capricious, made in bad faith, not supported by substantial evidence, or

erroneous on a question of law." Malhoit v. Southern California Retail Clerks Union, 754 F.2d 1133, 1135 (9th Cir., 1984), cert. denied, 469 U.S. 1189 (1985)

Not only does the beneficiary participant have the burden of meeting the Malhoit standards of proof to establish a right to the (limited) relief under the Act, but the case law has added to the burden by holding that even if there is proof that a fiduciary has failed to conform to statutory requirements, a beneficiary is not entitled to relief unless it can be demonstrated sufficient to convince the court that as a result of such violations substantive harm results to the beneficiary. Wolfe v. J. C. Penney Co., 710 F.2d 388, 393 (7th Cir., 1983); Ellenburg v. Brockway, Inc., 763 F.2d 1091, 1096 (9th Cir., 1985).

In agreeing with the District Court that MR. LOESCHNIG's benefits were properly terminated for failure to abide by a 30-day rule

to submit medical reports which was not contained in the SPD nor the Plan, it may be that the Ninth Circuit was following the above-noted rationale of the Wolfe and Ellenburg cases. However, the Wolfe and Ellenberg concept should not apply in this case because the statutory violations involved are much more than procedural. They are basic and fundamental to ERISA such that if they are ignored, a major purpose of the Act is denied. According to 29 U.S.C. §1102(a), "Every employee benefit plan shall be established and maintained pursuant to a written instrument," and Sections 101 of the Act and 102, included in 29 U.S.C. §1022(b), require that there be an SPD which contains "the plan's requirements respecting eligibility for participation and benefits." This express purpose of Congress was obviously violated by the respondent fiduciaries when MR. LOESCHNIG was refused benefits because of

a rule of eligibility which was not included in the SPD nor the Plan itself.

Section 404(A)(1) of the Act and 29 U.S.C. §1104 state that

> "A fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and ... (A) For the exclusive purpose of (i) providing benefits to participants and their beneficiaries; (B) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use ..."

Although the cases have allowed for the "prudent man" in ERISA actions to be something less than a Judge in our courts of law,[9/] this should not give the fiduciaries

---

[9/] "When a decision maker makes an effort to decide according to the evidence and the legal rules, the result satisfies this legal test whether or not the decision is the one a court would have made." Motor Vehicle Mfgrs. Assn. v. State Farm Mutual Auto. Inc. Co., 463 U.S. 29, 43, 103 S.Ct. 2856, 2867, 77 Law.Ed.2d 443 (1983).

of benefit plans a carte blanche to impose restrictions of eligibility which are not included in the SPD or the Plan. If restrictions on beneficiaries rights in addition to the above, are imposed consistent with the ruling of the Ninth Circuit and the District Court in this case, there would remain little, if any, remedial or procedural rights to beneficiary participants. According to the logic of the Ninth Circuit and the District Court, administrators of an ERISA health and welfare benefit plan may condition the dispensing of benefits on whatever regulations they deem necessary without including such in the SPD and/or the Plan itself. Allowing fiduciaries such prerogative would not be to the "interest of the participants and beneficiaries."

The respondents' letters which advised MR. LOESCHNIG of the denial of his benefits and his appeal (Appendices L-80, M-81)

also strike hard at the disclosure requirements that ERISA mandates. For these letters did not contain the real reason benefits were denied (i.e., 30-day reporting rule).

It can hardly be denied that a beneficiary participant's rights are substantively adversely affected by withholding information about the reason for denying benefits. The only way such individual can learn the true reasons for the denial is to file a lawsuit. The discounting from beneficiaries' pre-ERISA legal remedies by Congress (above) was done as a means for balancing equities. In return for giving up certain legal remedies, the beneficiary was to have a more secure, systemized, and assured manner of receiving benefits by providing a fairly administered claims program that eliminated expenses and delays of litigation.

A beneficiary participant should not have to go to the courts to learn the reason

his benefits are terminated, and, if he has to do so, he should be entitled to affirmative relief. Failure of fiduciaries to inform beneficiaries of the reasons for terminating benefits is contradictory to the letter and spirit of ERISA and should by law be declared arbitrary and capricious.

IV

IF RELIEF IS GRANTED ON THE MAJOR ISSUES OF THIS PETITION, IT SHOULD ALSO BE GRANTED ON SUBSIDIARY ISSUES.

The Ninth Circuit found (page 7 of its Memorandum, Appendix I-62) that:

> "Loeschnig's state wrongful discharge claims are predicated entirely upon his contention that Chrysler terminated his employment in order to deprive him of disability benefits."

It was admitted by CHRYSLER FINANCIAL that MR. LOESCHNIG's discharge was not related to his performance. The Pretrial

Conference Order specifies "It was at all times relevant the policy of defendants not to terminate individuals who are unable to work due to disability." (CR 59, p. 5[t].) Mr. Colton, employed by CHRYSLER entities for 21 years, had never known any employee to be terminated while he was on disability (RT p. 214, lns. 14-16; p. 245, ln. 20 - p. 246, ln. 21). Mr. Colton also testified that MR. LOESCHNIG was discharged from employment because he did not substantiate his disability (RT p. 232, lns. 5-25) and that the date for the discharge was selected by Mr. Slywka (RT pp. 232-236). Hence, the wrongful discharge count is closely related to the ERISA claim. It is therefore respectfully requested that, if the Court grant certiorari, and upon review, agree that MR. LOESCHNIG's ERISA benefits were wrongfully denied him, that the Court either review the issue of wrongful discharge or

return this issue to the trial court to re-decide in the light of the Court's ruling on MR. LOESCHNIG's ERISA claims. In addition, petitioner requests that the Court rule he is entitled to attorney fees in an amount to be decided by the lower courts. Such request was made in the Complaint and also in petitioner's Opening Brief (29 U.S.C. §1132[g][1]).

CONCLUSION

The opinion of the Ninth Circuit circumvents the statutory regulations designed to protect beneficiary participants, as it endorses the District Court's decision to allow eligibility for benefits under an ERISA health and welfare plan to be based on matters not part of the SPD (nor the Plan itself). Seen in the light of the already settled restrictions on beneficiary

participants, it is a gloomy outlook with respect to the rights and remedies of beneficiary participants. If we assume the premise that it is probable that at times, by intent or negligence, fiduciaries will cheat beneficiaries of their rightful benefits, and if there is added the opinion of the Ninth Circuit together with the previously mentioned constrictions on the remedies of beneficiaries, it can be fairly said that, with such combination, ERISA is anti participant beneficiary legislation.

Were the opinion of the Ninth Circuit law, fiduciaries could ignore statutory regulations with impunity and rely on self-made rules outside the SPD and still be sustained by the courts. While fiduciaries were taking such action, beneficiaries would be left out in the cold from a litigation standpoint, as the system would not provide a practical way for them to obtain relief.

The burden of proof to overcome self-made regulations would be too great to undertake the expenses and hazards of litigation. Without the concept of self-made regulations, beneficiaries realistically are placed in a financially difficult role because the state of the law is such that it does not guarantee attorney fees, even if there is a win. With the addition of the concept of self-made regulations, beneficiary cases would hardly be accepted by attorneys because the law would favor fiduciaries to the point where attorneys would be discouraged and turn away from such cases.

During argument before the Ninth Circuit, petitioner's counsel pointed out the numerous, unrebutted violations of ERISA and one of the Justices inquired as to whether counsel had a suggestion for the court to take in such cases. This query, together with the silence of the District Court and the Ninth Circuit

memoranda opinions on this issue, emphasizes that there is reason for the Supreme Court to grant a hearing for the purpose of establishing guidelines to utilize in ruling on cases involving violations of ERISA statutes pertaining to beneficiary participants.

Respectfully submitted,

LAW OFFICES OF
STEVEN ROSEMAN

By: STEVEN ROSEMAN

Attorneys for Petitioner

APPENDIX

87-1250

No. _____

Supreme Court, U.S.
FILED
MAR 22 1988
JOSEPH F. SPANIOL, JR.
CLERK

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1987

JOSEPH M. LOESCHNIG,

Petitioner,

vs.

CHRYSLER CREDIT CORPORATION, a corporation, CHRYSLER FINANCIAL CORPORATION, a corporation, CHRYSLER CORPORATION, a corporation,

Respondents.

APPENDIX TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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APPENDIX A

Section 101 of ERISA

SECTION 101 of ERISA

Part 1--Reporting and Disclosure

DUTY OF DISCLOSURE AND REPORTING

Act Sec. 101. (a) The administrator of each employee benefit plan shall cause to be furnished in accordance with section 104(b) to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan--

(1) a summary plan description described in section 102(a)(1); and

(2) the information described in sections 104(b)(3) and 105(a) and (c).

Act Sec. 101. (b) The administrator shall, in accordance with section 104(a), file with the Secretary--

(1) the summary plan description described in section 102(a)(1);

(2) a plan description containing the matter required in section 102(b);

(3) modifications and changes referred to in section 102(a)(2);

(4) the annual report containing the information required by section 103; and

(5) terminal and supplementary reports by subsection (c) of this section.

Act Sec. 101. (c)(1) Each administrator of an employee pension benefit plan which is winding up its affairs (without regard to the number of participants remaining in the plan) shall, in accordance with regulations prescribed by the Secretary, file such terminal reports as the Secretary may consider necessary. A copy of such report shall also be filed wih the Pension Benefit Guaranty Corporation.

(2) The Secretary may require terminal reports to be filed with regard

to any employee welfare benefit plan which is winding up its affairs in accordance with regulations promulgated by the Secretary.

(3) The Secretary may require that a plan described in paragraph (1) or (2) file a supplementary or terminal report with the annual report in the year such plan is terminated and that a copy of such supplementary or terminal report in the case of a plan described in paragraph (1) be also filed with the Pension Benefit Guaranty Corporation.

Act. Sec. 101. (d) Cross Reference.--

For regulations relating to co-ordination of reports to the Secretaries of Labor and the Treasury, see section 3004.

¶ 14,210 Act Sec. 101(a)

APPENDIX B

29 U.S.C. §1001

29 U.S.C. §1001

Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal Taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities,

and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing

anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance

It is hereby further declared to be the policy of this chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance. (Pub.L. 93-406, Title I, § 2, Sept. 2, 1974, 88 Stat. 832.)

APPENDIX C

Section 102, 29 U.S.C. § 1022 (1982)

Section 102, 29 U.S.C. § 1022 (1982)

Plan description and summary

plan description

(a)(1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be

furnished in accordance with section 1024(b)(1) of this title.

(2) A plan description (containing the information required by subsection (b) of this section) of any employee benefit plan shall be prepared on forms prescribed by the Secretary, and shall be filed with the Secretary as required by section 1024(a)(1) of this title. Any material modification in the terms of the plan and any change in the information described in subsection (b) of this section shall be filed in accordance with section 1024(a)(1)(D) of this title.

(b) The plan description and summary plan description shall contain the following information: The name and type of administration of the plan; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and

addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part

(including procedures required under section 1133 of this title).

(Pub.L. 93-406, Title I, § 102, Sept. 2, 1974, 88 Stat. 841.)

Regulations promulgated under Section 102 of ERISA, 29 U.S.C. 1022 (1982)

APPENDIX D

29 U.S.C. §1102

29 U.S.C. §1102

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(2) For purposes of this subchapter, the term "named fiduciary" means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly.

(b) Requisite features of plan

Every employee benefit plan shall--

(1) provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of this subchapter,

(2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan (including any procedure described in section 1105(c)(1) of this title),

(3) provide a procedure amending such plan, and for identifying the persons who have authority to amend the plan, and

(4) specify the basis on which payments are made to and from the plan.

(c) Optional features of plan

Any employee benefit plan may provide--

(1) that any person or group of persons may serve in more than one fiduciary capacity with respect to the plan (including service both as trustee and administrator);

(2) that a named fiduciary, or a fiduciary designated by a named fiduciary pursuant to a plan procedure described in section 1105(c)(1) of this title, may employ one or more persons to render advice with regard to any responsibility such fiduciary has under the plan; or

(3) that a person who is a named fiduciary with respect to control or management of the assets of the plan may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of a plan.

(Pub.L. 93-406, Title I, § 402, Sept. 2, 1974, 88 Stat. 875.)

APPENDIX E

Section 404, 29 U.S.C. §1104 (1982)

Section 404, 29 U.S.C. §1104 (1982)

Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342 and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and--

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of

large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

(2) In the case of an eligible individual account plan (as defined in section 1107(d)(3) of this title), the diversification requirement of paragraph (1)(C) and the prudence requirement (only to the extent that it requires diversidication) of paragraph (1)(B) is not violated by acquisition or holding of qualifying employer real property or qualifying employer securities (as defined in section 1107(d)(4) and (5) of this title).

(b) Indicia of ownership of assets outside jurisdiction of district courts

Except as authorized by the Secretary by

regulation, no fiduciary may maintain the indicia of ownership of any assets of a plan outside the jurisdiction of the district courts of the United States.

(c) Control over assets by participant or beneficiary

In the case of a pension plan which provides for individual accounts and permits a participant or beneficiary to exercise control over the assets in his account, if a participant or beneficiary exercises control over the assets in his account (as determined under regulations of the Secretary)--

(1) such participant or beneficiary Shall not be deemed to be a fiduciary by reason of such exercise, and

(2) no person who is otherwise a fiduciary shall be liable under this part for any loss, or by reason of any breach, which results from such

participant's or beneficiary's exercise of control.

(Pub.L. 93-406, Title I, § 404, Sept. 2, 1974, 88 Stat. 877; Pub.L. 96-364, Title III, § 309, Sept. 26, 1980, 94 Stat. 1296.)

APPENDIX F

Section 502, 29 U.S.C. §1132 (1982)

Section 502, 29 U.S.C. § 1132 (1982)

Civil Enforcement

(a) A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such

violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of [section] 105(c);

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title; or

(6) by the Secretary to collect any civil penalty under subsection (i).

(b)(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of the Internal Revenue Code of 1954 (or with respect to which an

application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) with respect to a violation of or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if--

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the

plan.

(2) The Secretary shall not initiate an action to enforce section 515.

(c) Any administrator who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from atters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

(d)(1) An employee benefit plan may sue or be sued under this title as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this title against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable

against any other person unless liability against such person is established in his individual capacity under this title.

(e)(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

(2) Where an action under this title is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) The district courts of the United States shall have jurisdiction, without regard to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g)(1) In any action under this title by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this title by a fiduciary for or on behalf of a plan to enforce section 515 in which a judgment in favor of the plan is awarded, the court shall award the plan--

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of--

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A).

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of the Internal Revenue Code of 1954;

(h) A copy of the complaint in any action under this title by participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) In the case of a transaction prohibited by section 406 by a part in interest with respect to a plan to which this part

applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved (as defined in section 4975(f)(4) of the Internal Revenue Code of 1954); except that if the transaction is not corrected (in such manner as the Secretary shall prescribe by regulation, which regulations shall be consistent with section 4975(f)(5) of such Code) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of such Code.

(j) In all civil actions under this title, attorneys appointed by the Secretary may represent the Secretary (except as provided

in section 518(a) of title 28, United States Code), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this Act, or to compel him to take action required under this title, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

4. Section 503, 29 U.S.C. § 1133 (1982). Claims Procedure.

In accordance with regulations of the Secretary, every employee benefit plan shall--

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

Regulations promulgated under Section 503 of ERISA, 29 U.S.C. 1133 (1982).

Section 2560.503-1, 29 C.F.R. § 2560-503-1 (1983). Claims Procedure.

(a) Scope and purpose.--(1) This section sets out certain mimimum requirements for employee benefit plan procedures pertaining to claims by participants and beneficiaries (claimants) for plan benefits, consideration

of such claims, and review of claim denials, hereinafter referred to in the aggregate as "claims procedures." Except as otherwise noted, these requirements apply to every employee benefit plan described in section 4(a) and not execmpted under section 4(b) of the Employee Retirement Income Security Act of 1974 (the Act).

(b) Obligation to establish a reasonable claims procedure. Every employee benefit plan shall establish and maintain reasonable claims procedures.

(1) A claims procedure will be deemed to be reasonable only if it:

(i) Complies with the provisions of paragraphs (d) through (h) of this section, except to the extent that it is deemed to comply with some or all of such provisions under the authority of paragraph (b)(2) or paragraph (j) of this section. [Amended by 46 FR 5882, originally scheduled to be

effective February 20, 1981. However, the effective date was delayed under the President's regulation freeze at least until March 30, 1981 (46 FR 11253).]

(ii) Is described in the summary plan description, as required by § 2520.102-3,

(iii) Does not contain any provision, and is not administered in a way, which unduly inhibits or hampers the initiation or processing of plan claims, and

(iv) Provides for informing participants in writing, in a timely fashion, of the time limits set forth in paragraphs (e)(3) and (g)(3) and subsection (h).

(2) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947, concerning joint representation on the board of trustees):

(i) Such plan will be deemed to comply with the provisions of paragraphs (d) through (h) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which dened claims are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (g) and (h) of this section (but will not be deemed to comply with paragraphs (d) through (f) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure in which denied claims are subject (but not provisions concerning the

final and initial disposition of benefit claims).

(c) Claims procedure for an insured welfare or pension plan.--(1) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for filing of a claim for benefits with and notice of decision by such company, service or organization.

(2) See paragraph (g) regarding review and final decision on denied claims by insurance companies, insurance services and similar organizations.

(d) Filing of a claim for benefits. For purposes of this section, a claim is a request for a plan benefit by a participant

or beneficiary. A claim is filed when the requirements of a reasonable claim filing procedure of a plan have been met. If a reasonable procedure for filing claims has not been established by the plan, a claim shall be deemed filed when a written or oral communication is made by the claimant or the claimant's authorized representative which is reasonably calculated to bring the claims to the attention of:

(1) In the case of a single employer plan, either the organizational unit which has customarily handled employee benefits matters of the employer, or any officer of the employer.

(2) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the joint board, association, committee or other similar group (or any member of any such

group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily have been referred.

(3) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization, which is subject to regulation under the insurance laws of one or more states, the person or organizational unit which handles claims for benefits under the plan or any officer of the insurance company, insurance service, or similar organization.

(4) For purposes of paragraphs (d) (1), (2), and (3) of this section, a communication shall be deemed to have been brought to the attention of an organizational unit if it is received by any person employed in such unit.

(e) Notification to claimant of decision.--

(1) If a claim is wholly or partially denied, notice of the decision, meeting the requirements of paragraph (f) of this section, shall be furnished to the claimant within a reasonable period of time after receipt of the claim by the plan.

(2) If notice of the denial of a claim is not furnished in accordance with paragraph (e)(1) of this section within a reasonable period of time, the claim shall be deemed denied and the claimant shall be permitted to proceed to the review stage described in paragraph (g) of this section.

(3) For purposes of paragraphs (e)(1) and (2), of this section, a period of time will be deemed to be unreasonable if it exceeds 90 days after receipt of the claim by the plan, unless special circumstances require an extension of time for processing the claim. If such an extension of time for

for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the dinal decision.

(f) Content of notice. A plan administrator or, if paragraph (c) of this section is applicable, the insurance company, insurance service, or other similar organization, shall provide to every claimant who is denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant;

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent plan

provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

(g) Review procedure. (1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized

representative may:

(i) Request a review upon written application to the plan;

(ii) Review pertinent documents; and

(iii) Submit issues and comments in writing.

(2) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims provedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service or organization. In each case, that company, service, or organization shall be the "appropriate named fiduciary" for purposes of this section. In all other cases, the "appropriate named fiduciary" for purposes of this section may be the plan administrator

or any other person designated by the plan, provided that such plan administrator or other person is either named in the plan instrument or is identified pursuant to a procedure set forth in the plan as the person who reviews and makes decisions on claim denials.

(3) A plan may establish a limited period within which a claimant must file any request for review of a denied claim. Such time limits must be reasonable and related to the nature of the benefit which is the subject of the claim and to other attendant circumstances. In no event may such a period expire less than 60 days after receipt by the claimant of written notification of denial of a claim.

(h) Decision on review.--(1)(i) A decision by an appropriate named fiduciary shall be made promptly, and shall not ordinarily be made later than 60 days after the plan's

receipt of a request for review, unless special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days after receipt of a request for review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary, which olds regularly scheduled meetings at least quarterly, a decision on review shall be made by no later than the date of the meeting of the committee or board which immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a decision may be made by no later than the date of the second meeting following the

plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require a further extension of time for processing, a decision shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review.

(2) If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension.

(3) The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, as well as specific references to the pertinent plan provisions on which the decision is based.

(4) The decision on review shall be furnished to the claimant within the appropriate time described in paragraph (h)(1) of this section. If the decision on review is not furnished within such time, the claim shall be deemed denied on review.

(i) Apprenticeship plans. This section does not apply to employee benefit plans which provide solely apprenticeship training benefits.

Effective date: This section becomes effective for claims filed on or after October 1, 1977.

(j) Qualified Health Maintenance Organizations. Claims procedures with respect to any benefits provided through membership in a qualified health maintenance organization, as defined in section 1310(d) of the Public Health Service Act, as amended, 42 U.S.C. § 300e-9(d), shall be deemed to satisfy the requirements of

this section with respect to the provision of such benefits to persons who are members of such qualified health maintenance organization, provided those procedures meet the requirements of section 1301 of the Public Health Service Act, as amended 42 U.S.C. § 300e and the regulations thereunder. [Added by 46 FR 5882, originally scheduled to be effective February 20, 1981. However, the effective date was delayed under the President's regulation freeze until March 30, 1981 (46 FR 11253).]

APPENDIX G

Section 510, 29 U.S.C. § 1140 (1982)

Section 510, 29 U.S.C. § 1140 (1982)

Interference with protected rights

It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, this subchapter, section 1201 of this title, or the Welfare and Pension Plans Disclosure Act [29 U.S.C.A. § 301 et seq.], or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan, this subchapter, or the Welfare and Pension Plans Disclosure Act. It shall be unlawful for any person to discharge, fine, suspend, expel, or discriminate against any person because he has given information or has testified or is about to testify in any inquiry or proceeding relating to this

chapter or the Welfare and Pension Plans Disclosure Act. The provisions of section 1132 of this title shall be applicable in the enforcement of this section.

(Pub.L. 93-406, Title I, § 510, Sept. 2. 1974, 88 Stat. 895.)

APPENDIX H

U.S.C.A. 9th Cir. ORDER Filed 12-28-87

FILED DEC 28 1987
Cathy A. Catterson, Clerk
U.S. COURT OF APPEALS

RECEIVED DEC 31 1987
Law Offices STEVEN ROSEMAN

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JOSEPH M. LOESCHNIG, Plaintiff-Appellant, vs. CHRYSLER CREDIT CORPORATION; CHRYSLER FINANCIAL CORPORATION; CHRYSLER CORPORATION; Defendants-Appellees.	C.A. No. 86-5975 D.C. No. CV-83-1350 DWW ORDER

Before: BEEZER and HALL, Circuit Judges,

and HARDY, District Judge*

The panel has voted to deny the petition for rehearing and to reject the suggestion for hearing en banc.

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* Honorable Chalres L. Hardy, United States District Judge, District of Arizona, sitting by designation.

The full court has been advised of the suggestion for rehearing en banc and no judge in active service has requested a vote to rehear the matter en banc.

Pursuant to Rule 35(b) of the Federal Rules of Appellate Procedure, the petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

APPENDIX I

U.S.C.A. 9th Cir. MEMORANDUM FILED 9-24-87

FILED SEP 24 1987
Cathy A. Catterson, Clerk
U.S. Court of Appeals

RECEIVED SEP 30 1987
Law Offices of STEVEN ROSEMAN

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JOHN M. LOESCHNIG,	) C.A. No. 86-5975
Plaintiff-Appellant,	)
vs.	) D.C. No. CV-83-1350-DWW
CHRYSLER CREDIT CORPORATION; CHRISLER FINANCIAL CORPORATION; CHRYSLER CORPORATION;	) MEMORANDUM*
Defendants-Appellees.	)

On Appeal From the United States District Court for the Central District of California
David W. Williams, District Judge, Presiding
Argued and Submitted May 6, 1987
Pasadena, California

Before: BEEZER and HALL, Circuit Judges, and HARDY, District Judge**

*This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by Ninth Cir. R. 36-3.

** See p. I-52

Joseph Loeschnig appeals from judgment on wrongful termination and pension deprivation claims he brought against Chrysler Credit Corporation, his former employer.[1/] Loeschnig's claims of error center on factual findings of the district court. Because the findings are not clearly erroneous, we affirm the judgment.

I

Background

Loeschnig began working for Chrysler in Southern California in 1967. He suffers from severe hypertension. Emotional stress associated with Loeschnig's work aggravated

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**Honorable Charles L. Hardy, United States District Judge, District of Arizona, sitting by designation.

[1/]Loeschnig also sues Chrysler Financial Corporation and Chrysler Corporation. Chrysler Financial administers Chrysler Credit's disability plans. Chrysler Corporation is the parent corporation of Chrysler Credit and Chrysler Financial. All defendants/appellees will be collectively referred to as "Chrysler" in this disposition.

his condition. In November 1981, Loeschnig experienced an attack of dizziness and was temporarily hospitalized. He informed Chrysler that he was physically unable to return to work and moved temporarily to Las Vegas.

Chrysler maintains twq ERISA disability leave plans for its employees. The Disability Absence Plan (DAP) provides coverage for temporary absences up to 12 months. The Long Term Disability Plan covers absences due to disability after DAP benefits have been exhausted. Both plans are administered by Chrysler pursuant to Employee Retirement Income Security Act, 29 U.S.C. §§ 1001 dt seq. (ERISA)

Terms of the DAP provide that a disabled employee must furnish medical proof of disability to Chrysler within 90 days and that Chrysler may require an employee on disability leave to undergo medical examinations at reasonable intervals. In

addition, the DAP requires periodic proof of continuing disability in the form of Attending Physician's Supplementary Statements (APSs).

Loeschnig submitted initial proof of disability in late November of 1981. Dr. Victor Gould of Chula Vista, California diagnosed Loeschnig as suffering from permanent malignant hypertension and opined that Loeschnig risked a stroke if Loeschnig continued in his job with Chrysler. Loeschnig submitted APSs by Dr. Gould to the same effect in December of 1981 and early January of 1982.

In January of 1982, Chrysler suspended payments to Loeschnig pending an independent examination by Dr. Russell Miller in Las Vegas. The examination confirmed Loeschnig's disability, and benefits were reinstated. However, Dr. Miller did not consider Loeschnig's disability permanent. Dr. Miller

became Loeschnig's treating physician.

In February of 1982, Chrysler informed Loeschnig that he must furhish APSs every 30 days. Loeschnig submitted APSs signed by Dr. Gould for February and March. Dr. Gould considered Loeschnig's condition permanent. Loeschnig submitted no APSs for April or May.

After Dr. Miller examined Loeschnig in June, Dr. Miller concluded that Loeschnig could return to work in a lesser capacity not involving emotional stress. Later that month, Chrysler arranged for a third opinion from Dr. McKinnon of Las Vegas in order to determine whether Loeschnig would be capable of returning to work in a non-stresful position.

Dr. McKinnon concluded that Loeschnig suffered from "severe arteriolar hypertension" rather than the more severe malignant hypertension diagnosed by Dr. Gould. Dr.

McKinnon further stated that Loeschnig might "be employable at some 'lesser' capacity," although Loeschnig appeared to be totally disabled at the time of the examination.[2/] ER 92-93. Dr. Miller reiterated his conclusion that Loeschnig could return to work in a lesser capacity and also noted that Loeschnig had failed to keep a follow-up appointment after the examination in June.

Loeschnig submitted his last APS on August 2, 1982. In that document, Dr. Gould stated that Loeschnig would "not be able to return to work until malignant hypertension is controlled." ER 97. In August, Chrysler notified Loeschnig that DAP benefits would be exhausted as of November 25, 1982 (12 months from Loeschnig's original application). An application for Long Term Disability

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[2/] Dr. McKinnon qualified this suggestion with the possibility that "lesser" employment could be demeaning and cause further unhealthy emotional distress.

Benefits was enclosed.

In October, Chrysler reminded Loeschnig of the necessity of applying for long term disability benefits. No application was forthcoming. On October 25, Chrysler learned that Loeschnig had failed to appear for a medical examination in Los Angeles with a Dr. Padova. This examination was ordered by the judge in Loeschnig's workers' compensation case.[3/] Loeschnig's failure to keep the appointment prompted Chrysler to review Loeschnig's file.

Chrysler informed Loeschnig on November 2 that his DAP benefits had been discontinued retroactive to Octoer 25. The same letter directed Loeschnig to return to work in Long Beach on Monday, November 8. Loeschnig

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[3/] Loeschnig filed a claim for workers' compensation in late December of 1981. Chrysler contested the claim. The California State Workers' Compensation Appeals Board eventually awarded compensation to Loeschnig.

did not report for work on November 8.[4/] On November 9, he visited Dr. Miller. Dr. Miller advised Loeschnig not to travel at that time. Chrysler terminated Loeschnig's employment on November 17, 1982.

Loeschnig returned his Long Term Disability Benefits application along with Dr. Miller's note advising Loeschnig not to travel. The Long Term Disability Benefit application indicated that Loeschnig suffered "moderate limitation of functional capacity" and was "capable of clerical/administrative (sedentary) activity."

By a letter dated November 15, Loeschnig requested that Chrysler review the decision to discontinue his disability benefits. Chrysler responded that termination of benefits was justified due to Loeschnig's

[4/] Loeschnig did not receive the letter until November 9. He had moved several times and had not apprised Chrysler of his current address or telephone number.

continued refusal to keep appointments with Dr. Padova (Loeschnig also failed to appear for an appointment with Dr. Padova the previous June) and absence of more conclusive medical information supporting Loeschnig's claim of total disability. Chrysler invited Loeschnig to furnish additional information concerning his disability. No such information was forthcoming.

II

Analysis

Loeschnig filed this lawsuit in federal court, alleging that Chrysler acted arbitrarily and capriciously under ERISA (29 U.S.C. § 1104(a)) in discontinuing his disability benefits and that he was wrongfully terminated under California law. After a $2\frac{1}{2}$ day bench trial, the district court ruled in Chrysler's favor on both claims. Loeschnig timely appealed. We have jurisdiction under 28 U.S.C. § 1291.

A. Claim for Disability Benefits

ERISA, 29 U.S.C. § 1104(a) requires ERISA fiduciaries such as Chrysler to administer plans for the sole purpose of providing benefits for participants and beneficiaries of plans and "with the care, skill, prudence, and diligence that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." We will uphold an ERISA fiduciary's decision to discontinue benefits unless plaintiff shows that the decision to discontinue benefits was arbitrary and capricious. Hurn v. Retirement Trust Fund, 703 F.2d 386, 389 (9th Cir. 1983).

We review the district court's findings of facts surrounding discontinuation of benefits for clear error. See Anderson v. City of Bessemer City, 470 U.S. 564 (1985).

"A finding is 'clearly erroneous' when although there is evidence to support it, the reviewing court on the entire record is left with the definite and firm conviction that a mistake has been committed." United States v. United States Bypsum Co., 333 U.S. 364, 395 (1948); see Anderson, 470 U.S. 564, 573 (1985). Whether, given certain facts, an ERISA fiduciary acted arbitrarily and capriciously is a question of law, which we review de novo. Hurn, 703 F.2d at 389.

The district court found that 1) Loeschnig was required to submit APSs every 30 days, 2)Loeschnig was timely notified of this requirement, 3) Loeschnig failed to provide medical information so that Chrysler could evaluate his continuing eligibility for disability benefits, 4) Chrysler did not terminate Loeschnig's benefits in bad faith, 5) Loeschnig evaded Chrysler's efforts to reach him and to discuss with him the

possibility of returning to work in a less stressful capacity, and 6) the 30 day APS requirement was reasonable.

We have reviewed the record carefully and cannot say that any of the district court's findings are clearly erroneous. Based on these facts, we agree with the district court that Chrysler did not act arbitrarily or capriciously in discontinuing Loeschnig's disability benefits.

B, Wrongful Discharge

Loeschnig's state wrongful discharge claims are predicated entirely upon his contention that Chrysler terminated his employment in order to deprive him of disability benefits. ERISA, 29 U.S.C. §§ 1332 (a)(3), 1140 preempts such claims. Sorosky v. Burroughs Corp., No. 85-5707, slip op. at 9, (9th Cir. Aug. 25, 1987).

Section 1140 prohibits, inter alia, discharge of a participant or beneficiary of

an ERISA plan "for exercising any right to which he is entitled under provisions of an employee benefit plan." 29 U.S.C. § 1140. The district court found that "Loeschnig was not terminated because of his failure to respond to request[s] for medical information about himself; he was terminated because of his failure to report to work upon the demand of his employer." ER 18. This finding is not clearly erroneous. Loeschnig was not discharged for attempting to exercise rights under Chrysler's disability plans.

III

Conclusion

The record supports the district court's finding that Loeschnig was required to submit proof of disability at thirty day intervals. Despite repeated reminders by Chrysler, Loeschnig failed to submit APSs or inform Chrysler of his whereabouts. Chrysler's

decision to terminate Loeschnig's disability benefits was not arbitrary or capricious. The record amply supports the district court's determination that Loeschnig was properly terminated pursuant to reasonable employment policies.

The judgment is affirmed.

AFFIRMED.

APPENDIX J

U.S.D.C. - CENTRAL DISTRICT OF CALIFORNIA

MEMORANDUM OF INTENDED OPINION

FILED MAY 1 1986

FILED MAY 1 1986
Clerk, U.S. District Court
Central District of California

RECEIVED May 5 1986
Law Offices of STEVEN ROSEMAN

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

JOSEPH M. LOESCHNIG, Plaintiff, vs. CHRYSLER CREDIT CORPORATION, et al., Defendant.	) No. CV 83-) 1350-DWW (JRx)))MEMORANDUM OF) INTENDED) OPINION))))

Joseph Loeschnig is a former employee of Chrysler Credit Corporation who was terminated after approximately fifteen years of service while he was on sick leave. This suit involves his claims that he was wrongfully suspended from receiving disability benefits and that he was wrongfully terminated from employment. A bench trial

was held on April 22 to 24, 1986 and the matter was taken under submission. After reviewing all of the evidence and hearing arguments of counsel, the court concludes that plaintiff has not sustained his burden of proof and that defendant is entitled to a judgment on both counts.

FACTS

Losechnig began his employment with Chrysler in 1967 in the San Diego area and became a part of a small staff in an office whose business was to service delinquent accounts of automobile purchasers, repossessed automobiles when the delinquency became quite serious, and to negotiate financial transactions with franchised dealers. About 1970 he was promoted to ajob title of inside adjustor, mostly telephoning delinquent customers. In 1981 he left the San Diego branch to go into a training program in Michigan for the job of auditor. After

completing the training he refused to assume the promotion because it called upon him to travel, and it disrupted his family life. He requested to return to his former job in San Diego. Because there was no opening, he was permitted to join the staff in the Long Beach branch, working at a lower job level with no reduction in salary. For several years prior to joining the Long Beach office he experienced headaches and irritability and made visists to a Dr. Gould who diagnosed him as having hypertension or high blood pressure. He claims that his illness was caused by the nature of his work inasmuch as he often had traumatic experiences with delinquent customers who objected to being dunned for payments and who would often become near-violant upon having their cars repossessed. In November 1981 Loeschnig experienced an attack of dizziness while at home and asked his wife

to drive him to a nearby hospital. En route his condition became so alarming that she stopped the car and telephoned for an ambulance which thusly transported him the rest of the way to the hospital. He received emergency care. A doctor assured him that he had not had a heart attack but that his blood pressure was elevated, and he was released after approximately one hour. His wife telephoned his place of employment to explain what had happened and to say that her husband was not physically able to return to his work. The Loeschnigs decided to move temporarily to Las Vegas where her parents lived and where the Loeschnigs often went to vacation.

The Chrysler Company has two disability plans for its employees. One is entitled "Disability Absence Plan" (DAP) and is a 12-month plan. The second, entitled Long-Term Disability Plan (LTD), is a plan which

commences upon expiration of the twelve-month DAP coverage and is available for extended disability periods. Loeschnig applied for disability leave which was granted. He was required under the plan to submit attending physicians' statements every thirty days as a condition to establishing his eligibility under DAP. The company requested plaintiff to submit to an examination by Dr. Russell Miller, a physician in the Las Vegas area. Dr. Miller confirmed that plaintiff had disabling hypertension and indicated that this was aggravated by the stress of his employment. Loeschnig's testimony was that he felt burned out, lacked work motivation and had psychological problems. He further testified that he wanted to get away from Chrysler and that he wanted to block out of his mind any thought of his past association with the company. During the eleven months

follcwing the hospital incident, Loeschnig did not on a single occasion contact any person connected with his employer. His absence from his job eventually came to the attention of Mr. Slywka and Mr. McCarter who were officers of the company Plan in Michigan who made several efforts to interview Loeschnig by telephone in Las Vegas. Each time plaintiff's wife would talk to the company officers and refuse to summon her husband to the telephone upon the ground that he was under sedation and required bed rest. However, the evidence further showed that Loeschnig admitted that he loved to gamble, that he spent six to eight hours a day - often five days a week-at the poker table and engaged in gambling on sporting events during the time he lived in Las Vegas. The company constantly urged plaintiff to comply with his obligation to furnish treating doctors' reports each thirty days so

that it could properly evaluate his condition and make a determination whether he continued to be eligible to receive benefits. During the eleven-month period the company set up three examination appointments for Loeschnig, two with the same doctor. The company experienced considerable difficulty contacting Loeschnig because he would change addresses without giving his employer notification. He followed a practice of evading their efforts to reach him and continually complained that he was being subjected to harassment by his employer.

It is quite true that Loeschnig suffered from aggravated hypertension. His blood pressure readings were at times in a very serious range but at other times showed response to medication. The various doctors who were involved agreed that he should not return to the stressful job that he left, but one suggested that he could return to

work if given less stressful duties. The evidence convinces me that Chrysler Company employees never followed unreasonable practices which were intended to upset Loeschnig or aggravate his condition. Loeschnig knew that the disability plan called for him to furnish physicians' reports of his condition every thirty days and, with few exceptions, he failed to comply with this requirement. A company with as many employees as Chrysler has every right to protect itself from being victimized by its work force by requiring employees on sick leave to periodically offer proof of continued illness. Otherwise, an employee could feign illness and stay away from his employment for long periods of time while still on the payroll. The evidence shows that Chrysler had a policy of actively discouraging its workers to separate from their jobs because of the difficulty of recruiting new workers and

training them as replacements.

Loeschnig takes the position that the company had an obligation to make him a written offer of a new job with non-stressful characteristics if it wanted him to return to work. The evidence indicates that officers of the company were willing to find desk duties for plaintiff which would not aggravate his condition but they were unable to get Loeschnig to keep an appointment with them to discuss the matter. Every effort to conciliate the problem was frustrated. Loeschnig's complaint that the company was attempting to find a reason for discontinuing his disability payments is without support. On the contrary, when the first twelve-month period was nearing its completion, the company mailed plaintiff a letter indicating that he should prepare to prove his eligibility for the long-term plan and sent forms to him which he failed to complete. Finally,

in November, 1982, the defendant, having received little evidence of Loeschnig's true medical condition and having no documentation which would support his entitlement to continued payments, wrote the plaintiff and directed him to return to work on a given day. When he failed to return to work his disability benefits were suspended and he was terminated pursuant to a portion of company policy which provided for this action.

WRONGFUL SUSPENSION OF BENEFITS CLAIM

I adopt the test that this court should determine whether the decision of the plan administrators reflected bad faith or was arbitrary or capricious. I conclude that the policy of requiring thirty-day reports was reasonable; that the plaintiff was timely notified of this obligation; that plaintiff failed in his obligation to provide medical information to defendants so that his

eligibility could be properly evaluated; that the plan administrators did not act in bad faith and their action was not arbitrary nor capricious but was fully appropriate to the strange antics and behavior of the plaintiff. The first claim is rejected.

WRONGFUL TERMINATION CLAIM

Plaintiff next contends that he was not accorded due process prior to his termination and that he should receive damages for being fired after a fifteen year tenure. California Labor Code Section 2922 provides that an employment relationship is terminable "at the will of either party on notice to the other" where there is no employee-employer agreement as to the term of employment. Case law has carved certain exceptions to this statutory "at-will" doctrine which do not support plaintiff's claim. Plaintiff cites Pugh v. See's Candies, Inc., 116 Cal.App.3d 311 (1981), as supporting his

position. Pugh has been severely discredited by later cases which seek to designate it as a case peculiar only to its facts, and I do not look upon it as an appropriate case to follow in this instance. While plaintiff was a fifteen year employee who had received average performance ratings and had enjoyed some promotion, there is no evidence that he received any assurances of continued employment by Chrysler supervisors while he was a company employee. Loeschnig was not terminated because of his failure to respond to request for medical information about himself; he was terminated because of his failure to report to work upon the demand of his employer.

Judgment is ordered in favor of the defendant. Defendant is ordered to lodge proposed findings of fact and conclusions of law and a form of judgment by May 9, 1986 and plaintiff may have until May 16,

1986 to file objections.

DATED: This (1) day of (May), 1986.

/s/
DAVID W. WILLIAMS,
Senior U.S. District Judge

APPENDIX K

U.S.D.C. - CENTRAL DISTRICT OF CALIFORNIA

NOTICE OF ENTRY ENTERED JUN 6 1986

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

Joseph M. Loeschnig

PLAINTIFF(S)

vs

Chrysler Credit Corporation, et al.,

DEFENDANT(S)

CASE NUMBER

CV 83-1350-DWW (JRx)

NOTICE OF ENTRY

TO THE ABOVE NAMED PARTIES AND TO THEIR ATTORNEY(S) OF RECORD:

You are hereby notified that Judgment & Ordered that plaintiff take nothing, that the action be dismissed on the merits, & that defendants, chrysler Corp., chrysler Credit Corp. & Chrysler Financiap corp. recover of plaintiff their cost. in the above entitled case was entered in the docket on JUN 6 1986 .

CERTIFICATE OF MAILING

I, Clerk of the United States District Court, Central District of California, and

not a party to the within action, hereby certify that on JUN 6 1985, I served a true copy of this notice of entry on the parties in the within action by depositing true copies thereof, enclosed in sealed envelopes, in the United States Mail in the United States Post Office mail box at Los Angeles, California, addressed as follows:

Steven Roseman
3rd Floor
1308 W. 8th Street
Los Angeles, CA. 90017

Peter J. Irsfeld, Esq.
James J. Walforf, Esq.
100 W. Broadway Ste. 900
Glendale,CA. 91210-0001

CLERK, U.S. DISTRICT COURT

By F.BLAIR ROBINSON
Deputy Clerk

APPENDIX L

LETTER from K. J. McCarter, Chrysler Corp.

to

Mr. Joseph M. Loeschnig

Dated November 2, 1982

CHRYSLER
FINANCIAL CORPORATION

November 2, 1982

Mr. Joseph M. Loeschnig
4340 El Esteban
Las Vegas, Nevada 89121

Dear Mr. Loeschnig:

Your Disability Absence Plan benefits are being discontinued effective October 25, 1982, due to your failure to substantiate your continuing disability by not reporting for a scheduled physical examination.

You are instructed to report for work to the Long Beach office, Suite 318, 4201 Long Beach Boulevard, Long Beach, California, at your normal starting time on Manday, November 8, 1982.

Very truly yours,

/s/
K. J. McCARTER - Specialist
Compensation and Benefits

KJM/ss
bcc: S. A. Morken
L-80

APPENDIX M

LETTER from Raymond Slywka, Chrysler Corp.

to

Steven Roseman

Dated January 5, 1983

CHRYSLER
FINANCIAL CORPORATION

January 5, 1983

Steven Roseman
Attorneys and Counselors at Law
1308 West 8th Street - 3rd Floor
Los Angeles, California 90017

Dear Mr. Roseman:

Your letter of November 15, 1982, directed to Disability Absence Plan Administrator, Chrysler Corporation, has been referred to this office for reply.

During the course of Mr. Loeschnig's disability absence from Chrysler Credit Corporation, Long Beach, California, the company had received independent medical opinions from two doctors in Las Vegas, Nevada. Their opinions differed on Mr. Loeschnig's ability to return to work with Chrysler Credit Corporation. Therefore, the examination scheduled with Dr. padova was relevant to resolve the question of whether

or not Mr. Loeschnig was able to return to work.

Mr. Loeschnig's continued refusal to attend the scheduled examinations with Dr. Padova left the company with no alternative other than to rely on the medical opinion of Dr. Russell Miller, Mr. Loeschnig's current attending physician, who advised the company on July 22, 1982, and again on November 2, 1982, that Mr. Loeschnig was able to return to work (copies attached). As a consequence, Mr. Loeschnig no longer met the eligibility requirements for continued benefits under the Disability Absence Plan.

In the absence of more conclusive medical information supporting Mr. Loeschnig's total disability, the decision to discontinue Disability Absence Benefits would appear to have been proper. If any such additional medical information is available and should

be made a part of his file, please forward it to us so that a further reappraisal can be made if warranted.

Very truly yours,

/s/
RAYMOND SLYWKA - Manager
Compensation and Benefits

RS/ss
Attach.

APPENDIX N

LIFE AND DISABILITY PROGRAM
for Chrysler Corporation

(Booklet)

CHRYSLER
CORPORATION

LIFE AND DISABILITY PROGRAM

for
MANAGEMENT--
EXECUTIVE
EMPLOYEES

EFFECTIVE
OCTOBER 29, 1979

This Booklet is intended an an easy-to-read decription of the main features of your Life and Disability Program:

- Group Life Insurance
- Permanent Total Disability
- Survivor Income Benefit
- Accidental Death and Dismemberment
- Voluntary Group Accident
- Disability Absence Plan
- Long Term Disability

The Insurance Benefits for Group Life, Permanent Total Disability, Survivor Income Benefit, Accidental Death and Dismemberment, and Voluntary Group Accident are underwritten by AEtna Life Insurance Company (hereinafter referred to as AEtna) under Group Policy Nos. GL-334000, GSI-334000, GC-334000 and ACC-345400 issued to Chrysler Corporation (hereinafter referred to as Chrysler). The Group policies are contracts between AEtna and Chrysler and may be changed or discontinued,

in whole or in part, at any time by written agreement between AEtna and Chrysler.

The Benefits for the Disability Absence Plan and the Long Term Disability Plan are provided by Chrysler and are subject in every respect to all provisions in the Plan of Benefits on file with Chrysler. These Plans are not underwritten by AEtna. However, AEtna will provide certain administrative services for the Long Term Disability Plan.

Chrysler reserves the right to modify, revoke, suspend, terminate or change the Program in whole or in part, at any time, except as limited by the provisions of any applicable Federal or state law.

The benefits described in this Booklet apply to you if you were actively at work on October 29, 1979. If you were not at work on October 29, 1979, the benefits described

in this Booklet apply to you on the first day worked thereafter. When this Booklet becomes applicable to you, it supersedes and replaces all prior Life and Disability booklets and certificates issued to you.

If you have any questions concerning your Life or Disability Program, please contact your local Personnel Department.

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I. Eligibility Provisions

A. Employees Covered

You are eligible for Life and Disability coverage if you are an active Management--Executive employee classified under one of the following group designations:

. Supervisory and Administrative Roll

. Management Roll

. Private Salary Roll

. Executive Roll

B. Effective Dates of Coverage

Your Group Life Insurance, Premanent Total Disability Insurance, Survivor Income Benefit Insurance and Accidental Death and Dismemberment Insurance become effective:

1. if you are a monthly paid employee, on the day your active employment commenced
2. if you are a bi-weekly paid employee, on the first day of the calendar month next following the month in which your active employment commenced.

Your Voluntary Group Accident Insurance becomes effective onthe same day you are eligible for Group Life Insurance, provided you enroll in accordance with the terms on page 4.

If you are a bi-weekly paid employee who is both disabled (i.e., ill or injured) and away from work, or on layoff or leave of absence on the effective date, the effective date of your Insurance coverage described above is deferred until you return to active work.

A bi-weekly paid employee who dies:

1. prior to becoming insured,
2. as a result of bodily injuries caused solely by employment with Chrysler, and
3. as a result of an accident in which the cause and result are unexpected as to time and place

will be considered insured for Group Life Insurance, Survivor Income Benefit Insurance

and Accidental Death and Dismemberment Insurance at the time of such death, provided an Accidental Death Benefit as described on page 4 would be payable if the employee would have been insured at the time of such injuries.

Your Disability Absence Plan and Long Term Disability Coverage becomes effective on the day after you complete one month of continuous service with Chrysler.

C. Increases or Decreases in Amounts of Insurance

An increase or decrease in the amounts of your insurance due to an increase or decrease in your Base Salary becomes effective on the first day of the month coinciding with or next following the date the change in your Base Salary becomes effective; provided, if you are both disabled (i.e., ill or injured) and away from work, or on a layoff or leave of absence on the date your

your insurance would otherwise be increased or decreased, the effective date will be deferred until you return to active work. However, if your Base Salary on your last day worked preceding the date of your disability or death would entitle you or your beneficiary to a higher amount of insurance, benefits are payable on the basis of the higher amount.

A change in the amount of your insurance because of a retroactive change in your Base Salary will become effective the date the change in your Base Salary is determined.

II. Group Life Insurance

A. Amount of Group Life Insurance Prior to Age 65

Your Life Insurance will be an amount equal to 200% of your Base Annual Salary.

See "General Definitions" **A.** and **B.** (page 8).

B. Amount of Group Life Insurance After Age 65

1. If you have 10 or more Years of Credited Service*, and you are insured for Group Life Insurance, your Life Insurance will be an amount equal to the lesser of:

. Your Original Amount of Insurance**,

or

. An amount calculated by reducing your Original Amount of Insurance** by 10%

---

*"Credited Service" is that which you have under the Chrysler Pension Plan on your 70the birthday. In addition, if you continue to work beyond age 68, you may count as Credited Service the months insured (prior to the date your corporate service is broken) between ages 68 and 70 in excess of the months of pension Credited Service you accrue between ages 68 and 70.

**"Original Amount of Insurance" is your Group Life Insurance amount at age 65 determined by your Base Annual Salary as of (1) your last day worked, or (2) your 65th birthday, whichever occurs first. Provided, however, if you become insured or continue to work after age 65, "Original Amount of Insurance" is your Group Life Insurance amount determined by your Base Annual Salary as of your last day worked and for purposes of the 10% reduction will be assumed to be your Group Life Insurance amount at age 65.

as of the first day of the seventh calendar month following the month of your 65th birthday and by an equal amount on the first day of each succeeding six months thereafter;

provided, however, that Life Insurance shall not be less than your Original Amount of Insurance** multiplied by 1½% times your years of Credited Service* (months of Credited Service may be counted when you have less than a full year) and this remaining amount of Group Life Insurance will be continued for your lifetime.

2. **If you have less than 10 Years of Credited Service*** and you are insured for Group Life Insurance, your Life Insurance will be determined as follows:

   a. If you terminate your employment at age 65, your Life Insurance will be reduced to $1,000 as of the first day

of the calendar month following the month of your 65th birthday.

b. If you terminate your employment after age 65, your Life Insurance will be in an amount equal to the lesser of:

. Your Original Amount of Insurance**, or

. An amount calculated by reducing your Original Amount of Insurance** by 10% as of the first day of the seventh calendar month following the month of your 65th birthday and by an equal amount on the first day of each succeeding six months thereafter;

provided, however, that Life Insurance will be reduced and limited to $1,000 as of the earliest to occur of:

. the first day of the calendar month following the month in which you terminate employment, or

. the date on which the 10% reduction reduces your Insurance to $1,000.

In either event (a. or b.) above, your Group Life Insurance of $1,000 wil be continued for your lifetime.

If you attain 10 years of Credited Service after your 65th birthday, your Life Insurance shall be reduced and continued as in 1. above.

3. **Conversion**

Each time your insurance under this Section B. is reduced, you will be entitled to the "Conversion Privilege" (page 10) as though your employment had terminated on the date each reduction occurs. The amount you will be entitled to convert to an individual policy will not exceed the amount of insurance lost as a result of the reduction.

C. Benefit Payment

If you die from any cause while insured, the amount of your Insurance is paid to your designated beneficiary. Payment will be in one sum unless you choose an installment method of payment described in the Group Policy. If you do not choose an installment method of payment, your beneficiary may do so after your death.

D. Beneficiary Provisions

You may designate or change your beneficiary at any time by making written request at your local Personnnel Department or at the AEtna Detroit Office:

Chrysler Beneficiary Unit,
Group Division
AEtna Life and Casualty
1414 Detroit Bank and Trust Building
Detroit, Michigan 48226

Your local Personnel Department has the necessary beneficiary forms. Any change of beneficiary becomes effective the date you

execute the request. However, AEtna will be fully discharged of its obligation if any payment is made before your signed request is received at its Detroit office.

If you designate more than one beneficiary, the surviving beneficiaries will share equally, unless you specifically proved otherwise.

If at your death, no designated beneficiary is living or if no valid beneficiary designation is in effect, payment will be made to your surviving spouse; if not surviving you, equally to your surviving children; if none survives you, equally to your parents or the survivor of them; if neither survives you, equally to your surviving brothers and sisters; or if none survies you, to your executors or administrators.

The terms of the Section D also apply to the "Accidental Death and Dismemberment" section

of this booklet (page 4).

E. Funeral and other Expenses

AEtna may deduct from the Group Life Insurance payable an amount not to exceed $500 for funeral and other expenses incidental to your last illness and death, but only when and to the extent this is desirable and equitable in its judgment.

III. Permanent Total Disability (PTD) Benefit

A. Eligibility

To be eligible for PTD benefits you must:

. Be totally disabled by bodily injury or disease so as to be prevented thereby from engaging in regular employment or occupation with Chrysler and your total disability must be permanent and continuous during the remainder of your life

. Be under age 70 and insured for Group Life Insurance when your total disability commenced

. Have less than 10 Years of Credited Service under the Chrysler Pension Plan when your total disability commenced

. Have exhausted all Disability Absence Plan and Long Term Disability benefits to which you are entitled, and on the date such benefits are exhausted, this PTD Benefit must still be in force as part of the Program.

B. Benefit Amounts

PTD benefits are payable in monthly installments at the rate of $20.00 for each $1,000 of Group Life Insurance in force at the time your total disability commenced until such amount of insurance, with interest on the unpaid balance, is exhausted. The final payment shall be only for the unpaid balance.

C. Permanent Total Disability Ceases

1. Return to Work at Chrysler

If you cease to be permanently and totally

disabled and return to active work with Chrysler, your Group Life Insurance amount will be reinstated as determined by your Base Salary. If you again become permanently and totally disabled, any PTD benefit payments for which you may become entitled will terminate when the total of those payments, plus the total of payments made for all prior periods of total disability commenced, plus interest accrued while monthly payments were made.

2. **Do Not Return to Work at Chrysler**

   If you cease to be permanently and totally disabled and do not return to work with Chrysler within 31 days after you recover, all insurance benefits will cease at the end of that 31 day period. However, within that 31 day period, you may convert any amount of insurance which would have been paid if you had not recovered (see

"Conversion Privilege", page 10).

D. Death

If you die while receiving monthly PTD installment payments, any remaining amount of insurance, including interest, will be paid in a lump sum to your beneficiary.

If you meet the eligibility requirements for PTD benefits and die within 12 months after premium payments for your Group Life Insurance have been discontinued, but before monthly installment payments commence, the amount of Group Life Insurance in force at the time your total disability commenced will be paid to your beneficiary; this payment will be in lieu of all other benefits provided under the Group Life Insurance Policy.

E. Payment Approvied for PTD Benefits

When your PTD claim is approved for payment by AEtna, the PTD benefit is in lieu of all

other benefits and privileges under the Group Life Insurance Policy.

F. Filing a Claim for PTD Benefits

You should make a claim to AEtna for a PTD benefit if you meet the eligibility requirements within 12 months after premium payments for your Group Life Insurance have been discontinued. Liability for a PTD benefit ceases if you do not file a claim within this 12 month period. Your Personnel Department has claim forms.

IV. Survivor Income Benefit

A. Transition Benefit

1. Eligibility

If you die while Group Life Insurance is in force and are survived by a widow, widower, child or parent who meets the definition of Survivor under Section IV, C., uour Survivor will receive a Transition Benefit for a maximum of 24 months. The first Transition

other benefits and privileges under the Group Life Insurance Policy.

F. Filing a Claim for PTD Benefits

You should make a claim to AEtna for a PTD benefit if you meet the eligibility requirements within 12 months after premium payments for your Group Life Insurance have been discontinued. Liability for a PTD benefit ceases if you do not file a claim within this 12 month period. Your Personnel Department has claim forms.

IV. Survivor Income Benefit

A. Transition Benefit

1. Eligibility

If you die while Group Life Insurance is in force and are survived by a widow, widower, child or parent who meets the definition of Survivor under Section IV, C., uour Survivor will receive a Transition Benefit for a maximum of 24 months. The first Transition

Benefit payment is due and payable on the first day of the month following your death. Subsequent payments are due and payable on the first day of each calendar month thereafter. The amount of the Transition Benefit is $300 for any month for which your Survivor is not eligible for an unreduced old-age benefit, a survivor's benefit not reduced because of age or a disability benefit under the Federal Social Security Act; and is $175 for any month for which your Survivor is eligible for such a benefit under the Federal Social Security Act.

Any month in which two or more Survivors share a Transition Benefit, each Survivor's share is computed as a fraction of the Transition Benefit which would be paid to that Survivor as a sole Survivor, according to his/her eligibility for Social Security benefits.

2. Payments

a. If you are survived by a widow or a widower, the Transition Benefit will be payable to that Furvivor; provided, however, that your widow or widower will not be paid the Transition Benefit for any month for which a higher surviving spouse benefit is payable under Section (2.6) of the Chrysler Pension Plan. Surviving spouse pension benefits so paid shall be counted as if paid under this section for the purpose of determining the maximum number of Transition Benefit payments payable.

If you are not survived by a widow or widower, the Transition Benefit will be payable to your children, or is none survive, to your parents.

b. If a widow or widower dies while Transition Benefits are still payable, any remaining payments will be made, in equal shares,

to your then surviving children; but if none are then surviving, in equal shares to your then surviving parents; but if no parent is then surviving, no further Transition Benefit payments will be made;

c. If a child dies while Transition Benefits are still payable, and if any other children are still alive, any remaining payments to the then surviving children will be proportionately increased because of the smaller number of Survivors receiving the Transition Benefits;

d. If a child dies while Transition Benefits are still payable, and if he is not survived by another child, any remaining payments will be made, in equal shares, to any of your parents then surviving, but if no parent is then surviving, no further Transition Benefit payments shall be made;

e. If a parent dies while Transition Benefits are still payable, and if he is survived by another of your parents, any remaining payments will be proportionately increased because of the smaller number of Survivors receiving the Transition Benefits;

f. If a parent dies while Transition Benefits are still payable, and he is not survived by another parent, no further Transition Benefit payments shall be made.

B. Bridge Benefit

1. Eligibility

If you are survived by a widow or widower who was 45 years of age or more on the date of your death or whose age (to the nearest 1/12) when combined with your years of Credited Service under the Chrysler Pension Plan, both of which shall be determined as of the date of your death, total 55 or more, and if 24

Transition Benefits have become due and payable to that Survivor, a Bridge Benefit of $300 per month is payable to the surviving widow or widower.

2. **Payments**

The Bridge Benefit is due and payable as of the first day of the month following the month for which the 24th Transition Benefit was due and payable, unless at that time the widow or widower is eligible to receive Mother's Insurance Benefits or a comparable benefit for a father, whether or not called a Father's Insurance Benefit, under the Federal Social Security Act, in which case payment of the Bridge Benefit shall be deferred until the widow or widower ceases to be eligible to receive such Mother's/Father's Insurance Benefits.

Each Bridge Benefit after the first is due and payable on the first day of each

calendar month thereafter; provided, however, that Bridge Benefits will not be paid beyond the earliest to occur of:

. The Survivor's death or remarriage; or

. The Survivor's attainment of age 62, or any lower age at which full Widow's or Widower's Benefits become payable under the Federal Social Security Act.

Your widow or widower will not be paid a Bridge Benefit for any month for which a higher surviving spouse benefit is payable under Section (2.6) of the Chrysler Pension Plan.

C. Definition of "Survivor"

1. Your widow or widower; but only if you were legally married to the widow or widower for at least one year immediately prior to your death.

2. Your child, but only if and while the child both:

. is unmarried, and

. meets at least one of the following requirements:

a. is under 21 years of age; or

b. is at least 21 but under 25 years of age; or

c. is at least 21 years of age and permanently and totally disabled;

provided, however, that a child who meets requirements b. or c. must also have been legally residing with and dependent upon you at the time of your death.

"Child" means a child born of a lawful marriage which you contracted, a child you legally adopted, your step-child or foster child.

3. Your natural parent, step-parent or foster parent, but only if you provided at least 50% of the parent's support during the calendar year preceding your

death (as defined by the Internal Revenue Code of the United States) and such parent was reported as a dependent on your most recent Federal Income Tax return.

Survivor Income Benefits are not payable to any Survivor, if, on the date of your death, you were either entitled to the Permanent Total Disability Benefit or were retired (unless you retired on a Permanent Total Disability Pension under the Chrysler Pension Plan and had not reached age 65).

V. Accidental Death and Dismemberment (AD&D) Benefit

If you have an accidental bodily injury and die or incur any other loss described below as a result of such accident, and die within one year of or incur any of the other losses within two years of such accident, you or

designated beneficiary (determined in the same way as your Group Life Insurance beneficiary) will receive the AD&D benefits described below, provided you are under age 70 and insured for this coverage at the time of such injury and at the time of such loss.

LOSS*	AD&D BENEFIT PAYMENT
Accidental death or accidental loss of more than one of the following: hand, foot, or sight of an eye	An amount equal to 100% of your Base Annual Salary (Full AD&D Benefit)
Accidental loss of one of the following: hand, foot, or sight of an eye	An amount equal to one-half of the Full AD&D Benefit

The total amount payable on account of more than one loss listed above sustained in any one accident shall not exceed an amount equal to 100% of your Base Annual Salary.

---

*"Loss" means, with regard to a hand or foot, severance at or above the writs or ankle joint; with regard to an eye, total and irrecoverable loss of sight.

The total amount of AD&D payable for a death which results from accidental bodily injuries caused solely by employement with Chrysler, and which results solely from an accident in which the cause and result are unexpected and definite as to time and place, shall be an amount equal to 200% of your Base Annual Salary at the date of the accident.

If you retire before age 65, your AD&D Insurance continues until the earlier to occur of (a) the date your Life Insurance terminates or (b) the last day of the month in which you reach age 65.

If you continue to work after age 65, your AD&D Insurance will be reduced in the same manner as "Amount of Group Life Insurance After Age 65" (page 1). Your AD&D coverage continues during your employment until the earlier to occur of (a) the date your Life Insurance terminates or (b) your attainment

of age 70.

Exclusions

No AD&D payment shall be made for any loss caused wholly or partly, directly or indirectly by:

1. Disease, or bodily or mental infirmity, or medical or surgical treatment thereof
2. Any infection, except infection caused by an external visible wound accidentally sustained
3. Self-destruction or intentionally self-inflicted injury, while sane or not
4. War, or any act of war, whether declared or undeclared, or
5. Your act of aggression, participation in a felonious enterprise or illegal use of drugs.

Conversion

AD&D Insurance cannot be converted to an individual policy.

VI. Voluntary Group Accident Insurance

A. Eligibility

If you are a monthly paid employee, you become eligible for Voluntary Group Accident Insurance on the day your employment with Chrysler commences. If you are a bi-weekly paid employee, you become eligible for Voluntary Group Accident Insurance on the first day of the calendar month next following the month in which you become a bi-weekly paid employee.

B. Effective Date of Insurance

If you become eligible for Voluntary Group Accident Insurance, you may immediately enroll for such Insurance. Your Insurance becomes effective on the first day of your eligibility for such Insurance provided you make written application to Chrysler on or before your eligibility date.

If you make written application after your eligibility date, your Insurance becomes

effective on the first day of the calendar month for which a payroll deduction is made for Voluntary Group Accident Insurance.

Your local Personnel Department has the necessary enrollment forms.

C. Benefit Amount

You may enroll for Voluntary Group Accident Insurance in even multiples of $25,000 up to a maximum of $250,000 ($500,000 if you are a Board Roll Executive).

You may increase (up to the maximum) or decrease your Insurance at any time you are insured by written request to Chrysler. The change in the amount of your insurance will be effective on the first day of the month for which your new payroll deduction is made.

D. Employee Contributions

You are required to contribute the entire premium for this Insurance. You will be

advised of the required premium at the time you enroll. The required premium will change each time your amount of Insurance changes; and if the premium rates are revised by AEtna. The required premiums are deducted from your salary.

E. Benefit Payments

If you have an accidental injury* and die or incur any of the other losses** described below as a result of such accident, and die or incur any of the other losses within one year of such accident, you or your beneficiary designated for Voluntary Group Accident Insurance will receive the benefits described below, provided you are insured for this

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* "Accidental Injury" is one that occurs directly and solely through external, violent and accidental means.

** "Loss" means, with regard to a hand or foot, severance through or above the wrist or ankle joint; with regard to the thumb and index finger, severance through or above the last joint of each; with regard to an eye, total and irrevocable loss of sight.

coverage at the time of such injury and at the time of such loss.

The total amount payable on account of more than one loss** listed below sustained in any one accident shall not exceed the full amount for which you are insured.

LOSS	BENEFIT PAYMENT
Accidental death or accidental loss of more than one of the following: hand, foot, or sight of an eye	An amount equal to the full Benefit Amount for which you are Insured
Accidental loss of one of the following: hand, foot, or sight of an eye	An amount equal to one-half of the Benefit Amount for which you are Insured
Accidental loss of thumb and index finger of same hand	An amount equal to one-quarter of the Benefit Amount for which you are Insured

Payment will be made in one sum unless a mode of settlement, subject to the provisions of the Group Policy, is arranged with AEtna.

F. Beneficiary Provisions

At the time you enroll you must designate a beneficiary for your Voluntary Group Accident Insurance. You may change your beneficiary at any time by making written request at your local Personnel Department.

Your local Personnel Department has the necessary Voluntary Group Accident beneficiary forms. A change of beneficiary will become effective the date you execute the request. However, AEtna will be completely discharged of its obligations if any Voluntary Group Accident Insurance benefit payment is made before your signed request is received.

If you designate more than one beneficiary, the surviving beneficiaries will share equally, unless you specifically provide otherwise.

If at your death, no designated beneficiary is living or if no valid beneficiary

designation is in effect, payment will be made to your surviving spouse; if not surviving you, equally to your surviving children; if none survives you, equally to your parents or the survivor of them; if neither survives you, equally to your surviving brothers and sisters; or if none survives you, to your executors or administrators.

G. Permanent and Total Disability (PTD)

PTD benefits are payable under the Voluntary Group Accident Insurance Program provided:

1. You sustain the injury in an accident while insured.
2. You become permanently and totally disabled as a result of that injury within 30 days of the date of the accident so as to be unable to perform every duty of your occupation during the first year of your disability; and, thereafter be

unable to engage in any occupation for the remainder of your life for which you are reasonably qualified by education, training or experience.

3. The disability has existed continuously for more than one year from the date you became permanently and totally disabled.

The PTD benefit is the full Benefit Amount for which you were insured on the date of your injury; less any amount paid or payable as a Voluntary Accident benefit because of a loss sustained as a result of your accident. You must submit initial proof of disability to AEtna within 90 days of the date the permanent and total disability begins and subsequent proof must be submitted within 90 days of the date the disability has continued for one year.

H. Limitations

Voluntary Group Accident Insurance Benefits are not payable for any loss or total

disability caused in whole or in part, directly or indirectly by:

1. Medical or surgical treatment (unless the loss is caused by an infection resulting directly from the injury or by surgery required as a result of the injury and performed within 90 days after the date of the injury)

2. Disease, ptomaines or infections

3. Self-destruction or intentionally self-inflicted injury, whether sane or not

4. War or any act of war, whether declared or undeclared

5. Traveling or flying in, or descending from, any kind of aircraft, spacecraft or other vehicle or device for aerial or space navigation; except that this exclusion will not apply:

   . if you are a passenger on an aircraft which is being used for the transportation

of passengers or of passengers and cargo, and if you have no duties whatever on or with respect to the aircraft

if you are travelling in an experimental plane or in a military aircraft as a passenger on Chrysler business

Note: The Group Policy also provides a benefit for pilots who have Voluntary Group Accident coverage and who make a separate request for the benefit and agree to make the required additional contribution. If you hold a valid pilot's license and desire this coverage, you may contact the AEtna Office in Detroit for further information. The telephone number is 313-237-5228.

I. Conversion

Voluntary Group Accident Insurance cannot be converted to an individual policy.

VII. Disability Absence Plan

A. Eligibility

To be eligible for Disability Absence Plan (DAP) benefits you must:

. Be disabled because of personal illness or injury after you have one or more months of Continuous Service with Chrysler

. Be unable to perform all duties of your occupation

. Be under the continuous care of a legally qualified physician who certifies your disability

. Furnish written notice of claim and satisfactory proof of disability on a timely basis as explained on page 6.

B. Commencement of Benefits

DAP benefits are payable commencing the first normal working day of disability in accordance with the schedule shown below.

C. Benefit Period

DAP benefits are payable for up to fifty-two weeks.

If you return to work following a disability absence, you must work full-time for at

least 30 consecutive days (vacation, holidays and layoff periods do not count as days worked nor as days absent for purposes of this provision) before you are eligible for a new maximum disability absence period (related or unrelated disability).

If you become disabled before taking the vacation you earned (accrued) in the prior year and remain disabled for the remander of the year, your DAP benefit will be interrupted for the period of your unused earned vacation. Any vacation earned in the year your disability commenced will be paid after DAP payments are exhausted.

Minimum Continuous Service at Beginning of Disability Absence*	Maximum Period and Amount of Regular DAP Benefits	
	Bi-Weekly Paid Employees	Monthly Paid Employees
1 month	4 weeks full pay** and 48 weeks at 60% of pay	1 month full pay** and 11 months at 60% of pay

1 year	9 weeks full pay and 43 weeks at 60% of pay	2 months full pay and 10 months at 60% of pay
2 years	13 weeks full pay and 39 weeks at 60% of pay	3 months full pay and 9 months at 60% of pay
5 years	26 weeks full pay and 26 weeks at 70% of pay	6 months full pay and 6 months at 70% of pay
10 years	30 weeks full pay and 22 weeks at 70% of pay	7 months full pay and 5 months at 70% of pay
15 years	35 weeks full pay and 17 weeks at 70% of pay	8 months full pay and 4 months at 70% of pay
20 years	39 weeks full pay and 13 weeks at 70% of pay	9 months full pay and 3 months at 70% of pay

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* A year of service is completed when you work the last scheduled work day prior to the anniversary of your latest day of hire

**Base weekly or base monthly salary rate exclusive of cost-of-living allowance, bonuses, commissions, overtime, shift premiums or any other special payments, fees or allowances. Normal payroll deductions are taken from DAP payments (e.g., Thrift Stock, Salaried Employees' Retirement Plan, FICA, etc.)

D. Occupational Disability

DAP benefits are payable for an occupational illness or injury arising out of and in the course of employment with Chrysler on the same terms as if the disability had been non-occupational. However, the weekly DAP benefit will be reduced by your Workers' Compensation or occupational illness entitlement (whether commuted or not and whether compromised or not as a redemption award or otherwise). Worker's Compensation payments for hospitalization, surgical, or medical expenses and payments or specific allowances for loss, or 100% loss of use of a body member or disfigurement, or permanent partial disability payments for a work-related disability unrelated to the disability for which benefits are being paid are <u>not</u> offset from DAP payments.

E. Partial Week Benefits

DAP benefits will be paid for a partial

week at a daily rate calculated by dividing the weekly benefit by 5 and multiplying the quotient by the number of normal working days you were disabled in the workweek for which a partial benefit is being paid.

F. Special DAP Payments-Change of Status

If you are notified of the effective date of one of the following employment status changes prior to the commencement of your disability, DAP payments are discontinued as of the effective date of the status change. At that time you may be eligible for Special DAP payments.

. Retirement before age 70
. Compulsory retirement at age 70
. Resignation
. Discharge
. Layoff
. Transfer from Management-Executive status to Hourly status

Special DAP payments are equivalent to the Sickness & Accident Benefits in the Insurance Schedule applicable to Clerical-Engineering-Technical employees. Special DAP benefits are payable for up to fifty-two weeks, reduced by the number of weekly DAP benefits paid since the commencement of your disability.

If you are transferred to a Clerical-Engineering-Technical position after your disability commenced, you will continue to receive DAP payments for the maximum period you are eligible.

When a Chrysler employee elects any Chrysler retirement benefit for which eligible, regular or special DAP payments are discontinued on the effective date of the retirement.

G. Disability During Temporary or Permanent Layoff

If you are on a temporary or permanent layoff and disqualified for State Unemployment Compensation benefits because of a disability,

you will be paid the equivalent of State Unemployment Compensation (UC) payments for the lesser of (1) the period of disability, (2) the period you are eligible for UC, or (3) until the date you are recalled to work.

If you remain disabled when recalled to work from a Temporary Layoff (i.e., date of return to work was determined prior to date layoff commenced), you will be eligible for DAP payments as of the effective date of your scheduled reinstatement. However, the maximum number of DAP payments will be reduced by the number of UC equivalent payments made since the commencement of your disability.

H. Written Notice of Disability

You must furnish written notice of claim to your local Salary Administrator within 20 days after the commencement of disability, or as soon thereafter as is reasonably possible.

I. Written Proof of Loss

You must furnish written proof of loss to your local Salary Administrator within 90 days after the termination of the period for which benefits are payable. Failure to furnish such proof within this period does not invalidate or reduce a claim if it was not reasonably possible to do so, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Chrysler will have the right and opportunity to have you examined when and as often as it may reasonably require during pendency of your disability absence.

VIII. Long Term Disability Benefit (LTD)

A. Eligibility

To be eligible for LTD benefits you must:

- Be covered under the Plan when your total disability began
- Have exhausted Regular DAP benefits and any unused earned (accrued) vacation entitlement (employees who exhaust Special DAP payments are not eligible for LTD Benefits)
- Be under the continuous care of a legally qualified physician who certifies your total disability
- Be totally disabled because of disease or injury so as during the first 24 months of your disability to be unable to perform the duties of your occupation, and after the first 24 months of disability be unable to engage in regular employment or occupation with Chrysler
- Apply for this benefit and furnish satisfactory proof of disability.

Benefits start for a period of Long term Disability on the day after you have

exhausted your DAP benefits if you meet all of the eligibility requirements.

B. LTD Amounts

LTD benefits are payable monthly for the period equal to your full months of Corporate Service, in excess of 12 months; at

- 50% of your Base Monthly Salary if you have less than 10 years of Credited Service; or
- 55% of your Base Monthly Salary if you have 10 or more years of Credited Service; but

not to exceed $15,000 per month.

After this period your LTD benefits are payable at 37½% of your Base Monthly Salary, not to exceed $11,250 per month.

C. LTD Reductions

LTD benefits are reduced by an amount equal to the monthly equivalent of the total of the following other income benefits:

1. all benefits under the Pension Plan or any other pension plan or retirement program then in effect to which Chrysler or any of its subsidiaries has contributed; provided, however, that benefits you are eligible to receive under the Chrysler Corporation Salaried Employees' Retirement Plan will be limited to 80% of the non-actuarially reduced contributory benefits and 100% of the non-actuarially reduced non-contributory benefits you are eligible to receive under the Plan, and

2. lost time benefits, including lump-sum settlements, under workers' compensation laws or other laws providing benefits for occupational injury, disease or pregnancy related condition, but excluding specific allowances for loss or 100% loss of use, of a body member, or permanent partial disability payments for a work-related disability unrelated to the disability

for which benefits are being paid, and

3. disability or old-age insurance benefits to which you are entitled (primary insurance amount) under the Federal Social Security Act or any future legislation providing similar benefits, except old-age benefits reduced because of the age at which received, and

4. benefits under any state or Federal law providing benefits for working time lost because of disability.

The amount of these reductions shall not be increased subsequent to the first day for which LTD benefits are payable, except that the amounts of such reductions may be increased in connection with any adjustment in the original determination.

The monthly equivalent of benefits paid on a weekly basis is computed by multiplying the weekly benefit rate by 4.33.

LTD benefit computations presume eligibility for Social Security Disability Insurance benefits and disability retirement benefits under the Pension Plan or any other pension plan or retirement program then in effect to which Chrysler or any of its subsidiaries has contributed, but such presumption of eligibility for disability retirement benefits shall not be made with respect to any LTD payments due for the 12 month period immediately following the date of expiration of the maximum number of weeks for which you are entitled to receive DAP benefits, and amounts deducted from LTD benefits on this basis are paid upon presentation of satisfactory evidence that these benefits were applied for and denied; provided, however, that a reduction in LTD benefits is made in an amount equal to Social Security disability insurance benefits (primary insurance amount) that would have been payable except for

refusal to accept vocational rehabilitation services.

AEtna has the right to require as part of the proof of claim for benefits under this section satisfactory evidence (a) as to the other income benefits for which you are eligible, (b) as to whether or not you have made application for other income benefits, (c) as to whether or not you have waived other income benefits at any time during the period for which you claim the benefits described in this section, and (d) of the amount of all other income benefits for which you are eligible.

D. Maximum Payment Period

The maximum period yo are eligible for LTD benefits is:

1. the date you no longer satisfy the disability requirements;
2. the end of the month in which you attain

age 65 (provided, however, that if you become disabled at or after age 63 and subsequently become eligible for LTD Benefits, such benefits will be payable for up to 12 months, but in no event beyond the end of the month in which you attain age 70); or

3. the date of your death.

Once a period of total disability has ended, a new period of disability will be treated separately. However, two periods of total disability which are not separated by a return to full time work for Chrysler for 30 or more days will be considered one period of disability.

If Monthly LTD benefits are discontinued because you no longer satisfy the disability requirements, and within 2 weeks of such discontinuance and prior to your return to work, you again become totally disabled as defined in the plan, LTD benefits will again

be payable.

E. Enrollment in Medicare Part B

If you are eligible for LTD benefits and enrolled in Medicare Part B under the Federal Social Security Act, you will receive a monthly special benefit equal to:

1. $7.20 for months prior to November 1, 1979,
2. $8.70 for months on or after November 1, 1979,
3. $9.20 for months on or after October 1, 1980,
4. $9.70 for months on or after October 1, 1981,

provided that in no event shall such payment commence prior to the first day of the month following the earlier of (a) the month during which age 65 is attained, or (b) receipt by Chrysler of application on a form provided for this purpose from an otherwise eligible employee under age 65, in which case such payment shall be made effective

for the month you enroll, but in no event prior to March 1, 1974; not more than one such payment shall be made to you for any one month; no such payment shall be made if you are receiving this amount under the Pension Plan.

F. Proof of Disability

Written proof of total disability for LTD benefits must be submitted within 90 days after the end of the witing period and subsequent written proof of the continuance of the disability must be furnished at such intervals as AEtna may reasonably require.

Proof of loss must cover the occurrence, the character, and the extent of the loss.

You may also be required, as part of the proof of claim for LTD benefits, to be examined as often as it may reasonably be required during pendency of your disability

To be eligible for LTD benefits, you must

also include satisfactory evidence that you made proper application for all "other income benefits" payable. Evidence satisfactoty to AEtna must be furnished that all of the proofs required to support such application for other income benefits have been submitted, and that such benefits have not subsequently been waived.

IX. General Definitions

A. "Base Annual Salary" excludes overtime, additions to straight time pay, incentive compensation awards, shift differentials, cost-of-living allowance and all other extra compensation

. for Monthly Paid Employees -- Base Annual Salary is equal to 12 times your base monthly salary

. for Bi-Weekly Paid employees -- Base Annual Salary is equal to your base bi-weekly salary divided by .46 and the result multiplied by 12.

Base Annual Salary to be used in computing the amount of insurance determined from 200% or 100% of the Base Annual Salary shall include the weekly "add-on" of $52.80 (where applicable) (1) during the period February 25, 1980 through November 30, 1980 for bi-weekly paid employees and (2) during the period March 1, 1980 through November 30, 1980 for monthly paid employees in grades 9, 10 and 11.

B. "200% or 200% of Base Annual Salary". If the amount of insurance determined from 200% or 100% of your Base Annual Salary is not a multiple of $500, it will be raised to the next higher multiple of $500. This does not apply to the reduced amount after Age 65.

C. For employees not covered under the Chrysler Pension Plan, "Credited Service" will be determined according to the rules

under the Chrysler Pension Plan.

D. "Physician" means only a legally qualified physician.

E. "Federal Social Security Act" means the Federal Social Security Act as now in effect or as hereafter amended.

F. "Amount of Life Insurance in force" is the amount (exclusive of any Survivor Income Benefit) for which you are covered under the Group Life Insurance Policy.

X. How to Obtain Life and Disability Benefits

A. When to apply for benefits:

All requests should be reported promptly.

B. Where to apply for benefits

In the event of an employee's Disability or Death, the local Chrysler Personnel Office should be contacted.

In the event of a retiree's Death, either the local Chrysler Personnel Office or the

Chrysler Corporate Group Insurance Office (313/956-3962) should be contacted.

You will be provided forms and instructions for filing an application for benefits.

C. How to apply for benefits

Please complete the forms and provide any requested documents.

XI. Termination of Life Insurance and Disability Coverage

If you are an active employee, your Life Insurance and Disability Coverage will terminate in the event of:

A. Resignation

If you resign, your Life Insurance and Disability Coverage will cease as of your last day worked and your Voluntary Group Accident Insurance will cease at the end of the month for which the premium has been paid.

B. Discharge

If you are discharged, your Life Insurance

and Disability Coverage will cease as of your last day worked and your Voluntary Group Accident Insurance will cease at the end of the month for which the premium has been paid.

C. Layoff

If you are laid off, your Group Life Insurance, Permanent Total Disability Insurance, Survivor Income Benefit Insurance and Accidental Death and Dismemberment Insurance will continue until the end of the calendar month following the calendar month in which your layoff commenced and thereafter, without cost to you, for up to 12 additional months. Following the last month of Corporation paid coverage, you may continue coverage for the next 12 months by paying the required premium at your plant or office. Should your Corporate Service be broken for any reason, coverage terminates at the end of the month in which such break in service occurs.

Your Disability coverage will cease as of the effective date of your layoff. If you are notified of the effective date of layoff prior to the commencement of a disability, DAP payments cease as of the effective date of layoff. At that time, you may be eligible for Special Disability Absence Plan payments (page 6).

Your Voluntary Group Accident Insurance will cease at the end of the month for which the premium has been paid.

D. Personal Leave of Absence

If you are on an approved personal leave of absence, your Group Life Insurance, Permanent Total Disability Insurance, Survivor Income Benefit Insurance, and Accidental Death and Dismemberment Insurance will cease as of the end of the month following the month in which your leave commenced. Thereafter, you may continue your coverage for the next 12 months by paying the

required monthly premium at your plant or office.

Your Voluntary Group Accident Insurance will cease at the end of the period for which the premium has been paid.

Your Disability coverage will cease as of your last day worked.

E. Disability Leave of Absence

If you are on an approved disability leave of absence, your Group Life Insurance, Permanent Total Disability Insurance, Survivor Income Benefit Insurance and Accidental Death and Dismemberment Insurance will continue without cost to you as long as you continue to be unable to work because of your disability for the period equal to your Corporate Service at the time your disability commenced.

Your Voluntary Group Accident Insurance will continue for the period premiums are deducted

from your DAP payments.

XII. Miscellaneous Provisions

As used in this section, the term "Life Insurance" includes PTD Benefits and Survivor Income Benefits.

A. Assignment

You may assign your Group Life Insurance, Accidental Death and Dismemberment Insurance and Voluntary Group Accident Insurance if all Group Policy requirements are met. Neither you nor your beneficiary may assign any other benefits to anyone.

B. Claims of Creditors

Group Life Insurance and Accidental Death and Dismemberment Insurance are exempt from legal or equitable process for your debts or those of your beneficiary, to the extent permitted under any applicable law.

C. Legal Action

No legal action may be brought to recover

under any benefit, except for Group Life Insurance, after three years from the deadline for filing a claim.

AEtna will never attempt to reduce or deny a benefit payable for a loss to any person on the grounds that a disease or condition existed before coverage became effective, if the loss occurs more than two years from the date coverage commenced. This provision will not apply to conditions specifically excluded elsewhere in this booklet.

D. Misstatements

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

E. Proof of Disability

Written proof covering the occurrence, the nature and the extent of your disability must be furnished to AEtna. Subsequent

written proof of the continuance of such disability must be furnished to AEtna at such intervals as AEtna may reasonably require.

F. Payment Of Claims

Upon receipt of due proof of claim, (1) Disability benefits will be paid to you at the end of each period for which benefits are payable, and any balance remaining unpaid at the termination of that period will be paid immediately, (2) any benefit payable for loss of your life will be paid as provided in this Booklet-Certificate and in the Group Policy, and (3) all other benefits will be paid to you.

If any benefit (except Life Insurance) is payable to your estate, to yur beneficiary who is a minor or to someone otherwise not competent to give a valid release, AEtna may pay that benefit up to an amount not exceeding $1,000 to any relative by blood or

marriage who is deemed by AEtna to be equitably entitled to the benefit. Any payment made by AEtna in good faith pursuant to this provision shall duly discharge AEtna to the extent of that payment.

G. Determination by the Policyholder

Subject to adjustment for error, the determination and findings made in good faith by Chrysler with respect to -- (1) the fact and time of commencement, duration and termination of an Employee's employment, layoff, leave of absence, or absence because of sickness or injury, (2) an Employee's Base Salary, (3) any fact relating to any Chrysler retirement plan, (4) the fact that, as of any given time, an Employee is, or is not, covered for all benefits for which he is eligible under the Group Policies or any state plan policy, and (5) the amount of the employee's benefits, if any, under the Group Policies or any state plan policy as of any

given time will be conclusive and binding upon all prrsons for the purposes of coverage described in this Booklet-Certificate.

XIII. Conversion Privilege

If all or a portion of your Group Life Insurance terminates, because your employment terminates or if any of your insurance terminates because of your age or retirement, the amount of Group Life Insurance which terminates including the value of Survivor Income Benefits may be converted, in total or to a lesser amount, to an individual life insurance policy. AEtna will determine the value of Survivor Income Benefits on the basis of your age, and reasonable assumptions as to mortality, interest, and other contingencies affecting the payment of benefits. Accidental Death and Dismemberment Insurance and Voluntary Group Accident Insurance cannot be converted to an individual policy.

Your converted policy may be any kind of individual policy then customarily being issued by AEtna for the amount being converted and for your age (nearest birthday) on the date it will be issued, except that AEtna will not offer a term policy or one with disability or other supplementary benefits.

When Group Life Insurance ceases because that part of the group contract discontinues as to your employee class, and insurance on your life has been in force under the group contract for at least 5 consecutive years prior to such discontinuance, the amount that ceases less the amount of any group life insurance for which you become eligible within 31 days of discontinuance may be converted to an individual policy. The maximum amount which you can convert in any event is $2,000.

In order to convert, written application

must be made for an individual policy and the first premium must be paid on it within 31 days after cessation of insurance for any of the above reasons. Contact your local AEtna office for an application form.

No evidence of insurability will be required.

The individual policy will become effective at the end of the 31 day period during which conversion is permitted.

The premiums for the converted policy will be at AEtna's then customary rates for the same policy issued to any other person of the same class of risk and age at the time the converted policy becomes effective.

An individual policy will be in exchange for all benefits and privileges under the Group Life Insurance Policy, except with respect to any amount of Life Insurance which may be continued after the effective date of the individual policy, as described in the

"Amount of Group Life Insurance After Age 65" section (page 1).

Death Protection During 31 Day Conversion Period

If death should occur during the 31 day conversion period and before any insurance under an individual policy becomes effective, the maximum amount for which you are entitled to apply under the individual policy is payable under the Life Insurance Policy whether or not you applied for an individual policy. However, if death should occur during the 31 day conversion period described in the "Amount of Group Life Insurance After Age 65" section, this will not apply to the Final Amount of Insurance which is not subject to reduction. As used herein, "amount of insurance you are entitled to have issued to you under an individual policy" does not include any Survivor Income Benefit.

XIV. Benefit Payments

All Insurance claims for Group Life, Permanent Total Disability, Survivor Income Benefits, Accidental Death and Dismemberment, and Voluntary Group Accident will be processed by Chrysler or AEtna. Insurance Benefit payments will be made by AEtna.

All Disability Absence Plan Benefit payments will be processed and made by Chrysler.

All Long Term Disability benefit payments will be processed by AEtna. Benefit payments will be made by Chrysler through Hartford National Bank & Trust Company, as Trustee of the Chrysler Employee Benefit Trust.

The Insurance Benefits for Group Life, Permanent Total Disability, Survivor Income Benefit, Accidental Death and Dismemberment and Voluntary Group Accident set forth in this booklet are effective only if you are

eligible for coverage, become covered, and remain covered in accordance with the provisions of the applicable Group Policy.

If you become covered, section I through VI and sections IX through XIV of this booklet will become your Certificate of Coverage.

The insurance described in this Booklet-Certificate will be provided under AEtna Life Insurance company policy forms GR-22-SML, GR-25-SM, GR-23-SMH and GR-34-SM.

AETNA LIFE INSURANCE COMPANY

Additional Information Regarding Summary Plan Description

The following information, provided by Chrysler Corporation, is added to this document for purposes of convenience but is not part of your Certificate of Coverage. This information and the information set forth in this Booklet-Certificate provides

you with the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 (ERISA).

Life and Disability Benefits are provided through the Group Insurance Program and Group Accident Insurance Program which are welfare plans as defined by ERISA. Plan requirements regarding eligibility for participation and benefits and termination of coverage are described in this booklet. The Employer Identification Number, assiged by the Internal Revenue Service to Chrysler Corporation, is 38041996o. The Plan Numbers are 501 for Life, Survivor Income Benefits, Accidental Death and Dismemberment, and Long Term Disability and 513 for Voluntary Group Accident. All benefits except Disability Absence Plan and Long Term Disability are administered under an insurance contract arrangement. The Disability Absence Plan is self administered and the Long Term Disability

is administered under an administrative service contract arrangement.

The plan administrator is Chrysler Corporation, Chrysler Center, 12000 Lynn Townsend Drive, Highland Park, Michigan*. Service of legal process may e made upon the plan administrator. The agent for service of legal process is Office of the Secretary, Chrysler Corporation, Chrysler Center, 12000 Lynn Townsend Drive, Highland Park, Michigan*.

Except as otherwise provided in this booklet, the benefits described herein are provided without cost to you. All costs of the Plan are paid by Chrysler Corporation as such costs are incurred. Records of the plan are kept on a claendar year basis.

The procedure to be followed with respect

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*The mailing address of Chrysler Corporation is P.O.Box 1919, Detroit, Michigan 48288.

The telephone number of the Corporate Group Insurance Office is 313-956-3962

to filing a claim and obtaining claim forms is described in this Booklet-Certificate.

If a claim for Life Insurance, Survivor Income Benefit Insurance or Accidental Death and Dismemberment Insurance is denied in whole or in part, a notice will be sent explaining the reason for the denial. If there are any questions concerning the denial, inquiry should be made within 60 days from the date the claim was denied to the Chrysler Corporate Group Insurance Office. The letter should state the reason the claim should not have been denied and should include a copy of the notice and any additional documents, records, information or comments which have a bearing on the claim. Written notice of the decision will be sent within 60 days after receipt of the appeal.

If a Disability claim is denied in whole or in part, you will receive a notice explaining the reason for the denial. If you have any

questions concerning the denial, you should contact your local Personnel Office within 60 days from the date the claim was denied. Your appeal will be reviewed and a reply made within 60 days of the date the appeal is received.

Statement of ERISA Rights

As a participant in the Life and Disability Program you are entitled to certain rights and protections under the employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the plan administrator's office or at your plant Personnel Department, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual report and plan descriptions.

2. Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

3. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the perople who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to

prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that

plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

APPENDIX O

LETTER from K. J. McCarter - Chrysler Corp.

to

Mr. Joseph M. Loeschnig

Dated February 16, 1982

CHRYSLER
FINANCIAL CORPORATION

February 16, 1982

Mr. Joseph M. Loeschnig
378 First Avenue
Chula Vista, CA 92011

Dear Mr. Loeschnig:

The results of your independent medical examination from Dr. Russell Miller have found you disabled at the present time. Dr. Miller further indicated in a conversation with this office that your condition hopefully will improve with time and appropriate medical care.

Since the Disability Absence Plan requires that employees receiving benefits be under the continuous care of a legally qualified physician who certifies the disability and that the employees furnish satisfactory proof of disability on a timely basis, it is requested that you arrange for the completion and return of the enclosed

Attending Physician's Supplementary Statement. You can anticipate receiving and filing these supplemental reports at thirty (30) day intervals until such time as you are cleared to return to work.

To ensure that this communication reaches you, I have sent this letter to both your Chula Vista, California and Las Vegas, Nevada addresses.

Should you have any questions please do not hesitate to contact me.

Very truly yours,

/s/
K. J. McCARTER -
Administrator
Compensation and Benefits

KJM/ss
Enclosure

(3)

Supreme Court, U.S.
FILED
APR 11 1988
JOSEPH F. SPANIOL, JR.
CLERK

No. 87-1580

In The

Supreme Court of the United States

October Term, 1987

—o—

JOSEPH M. LOESCHNIG,

Petitioner,

vs.

CHRYSLER CREDIT CORPORATION, a corporation, CHRYSLER FINANCIAL CORPORATION, a corporation, CHRYSLER CORPORATION, a corporation,

Respondents.

—o—

RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

—o—

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QUESTION PRESENTED

If a beneficiary participant of a health and welfare plan under the Employees Retirement Income Security Act (ERISA) does not comply with the continuing eligibility requirements in the Summary Plan Description (SPD) and the Plan itself, can benefits be discontinued by the Plan's fiduciaries?

PARTIES TO THE PROCEEDING

Respondents agree with Petitioner's statement, with the clarification that Chrysler Financial Corporation is a wholly-owned subsidiary of Chrysler Corporation, and that Chrysler Credit Corporation is a wholly-owned subsidiary of Chrysler Financial Corporation.

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No. 87-1580

In The

Supreme Court of the United States

October Term, 1987

JOSEPH M. LOESCHNIG,

Petitioner,

vs.

CHRYSLER CREDIT CORPORATION, a corporation, CHRYSLER FINANCIAL CORPORATION, a corporation, CHRYSLER CORPORATION, a corporation,

Respondents.

RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

OPINIONS AND JUDGMENTS IN COURTS BELOW

Respondents basically agree with the recitation by Petitioner. Respondents add, however, that Findings of Fact and Conclusions of Law in the Trial Court were entered on June 6, 1986, superseding the Memorandum of Intended Opinion. These are included as Appendix A to this Brief. The Judgment of the Trial Court is attached as Appendix B to this Brief.

STATEMENT OF ALLEGED JURISDICTION

Although never specified by him, Petitioner apparently attempts to invoke the jurisdiction of this Court pursuant to Rule 17(a) of the Court Rules of the Supreme Court of the United States and 28 U.S.C. section 2101(c), requiring a Petition for Writ of Certiorari to be filed within ninety days after the entry of a judgment or decree in a civil action, where an alleged conflict exists between the decisions of various federal courts of appeals on similar matters.

As noted below, however, Respondents respectfully submit that no such jurisdiction exists in this case, as there is no conflict between the decisions of the lower courts in this case and those cited by Petitioner.

STATUTES AND REGULATIONS INVOLVED

Respondents agree with Petitioner's statement.

STATEMENT OF THE CASE

Petitioner was employed by Respondent, Chrysler Credit Corporation ("Credit"), on September 18, 1967, where he was assigned to the San Diego branch (CR 59, p.3). In 1979, Petitioner requested a transfer from the San Diego branch, and was assigned the position of Branch Auditor, and given training in that capacity. After a few months in the capacity of Branch Auditor, he was trans-

ferred to the Long Beach branch, again at his request (RT 311-13). Although the Long Beach branch did not have an opening for a person of Petitioner's seniority, they accommodated his request and assigned him to temporary duties as a telephone adjuster (RT 38-40). No reduction in salary accompanied any of these transfers (RT 39). On November 19, 1981, Petitioner left his employment with Credit and applied for disability leave (CR 59, p.3). The medical condition for which Petitioner was granted disability is described as "hypertension," evidenced by high blood pressure (RT 382-390).

Respondent, Chrysler Corporation ("Chrysler"), maintains two disability leave plans (RT 56-57). One is entitled "Disability Absence Plan" (DAP) and is a 12-month plan (Exhibit 206). The second is entitled "Long Term Disability Plan" (LTD) and is a plan which commenced upon expiration of the 12-month DAP coverage and is available for extended disability periods (Exhibit 207). Respondent, Chrysler Financial Corporation ("Financial"), administers the DAP plan for employees of Credit (RT 47-50).

Upon commencing his disability period, Petitioner and his wife relocated in the San Diego area, where they remained for a short period of time, then moved to Las Vegas (RT 279-280). On January 15, 1982, at the request of Financial, Petitioner was examined by Russell F. Miller, M.D., a physician in the Las Vegas area (Exhibit 11). Dr. Miller confirmed the disability of Petitioner (Exhibit 11), and thereafter, became Petitioner's regular treating physician (RT 289-290).

On July 26, 1982, Financial received a letter from Dr. Miller indicating that Petitioner could return to work in

a lesser capacity, not involving emotional stress (Exhibit 28). Financial had previously discussed with Mr. Roseman, Petitioner's counsel, that it was Credit's intention to return Petitioner to work in a capacity which would accommodate any continuing disability of Petitioner (Exhibit 35, p.8; RT 152-153).

On October 25, 1982, Financial was informed that Petitioner had failed to appear in California for an examination with Dr. Padova as ordered by the Judge in Petitioner's worker's compensation case. This failure to appear prompted a review by Financial of Petitioner's disability file (RT 211-212). Based upon this review, it was determined to send Petitioner a letter informing him that his payments under the DAP were being discontinued and requesting him to return to work on November 8, 1982, at the Long Beach, California branch of Credit (Exhibit 35, p.11; RT 162, 103-105, 212). This action was taken because, in Financial's opinion, Petitioner had failed to furnish evidence of a continuing disability (Exhibit 35, p.11; RT 116-117, 104-105).

Petitioner did not report for work on November 8, 1982, and, in fact, did not even contact Financial or Credit (RT 305-306). On November 17, 1982, Financial sent Petitioner a letter terminating his employment (Exhibit 39).

Petitioner was obligated under DAP to provide attending physician's supplements every 30 days (Exhibit 206, p.13). However, as of October, 1982, Financial had received only one physician's supplement from Petitioner within the preceding four months, and that statement was from a Dr. Gould, who was not Petitioner's treating physician (RT 122-124).

Petitioner's disability payments were *not* discontinued because he failed to appear for the Dr. Padova examination. As of October, 1982, it appeared to Financial that Dr. Miller was Petitioner's treating physician. Petitioner admitted that Dr. Miller had been his treating physician since June 1, 1982 (RT 290). On July 16, 1982, Financial received Dr. McKinnon's report (Exhibit 25). On July 26, 1982, Financial received a report from Dr. Miller (Exhibit 28). The only other physician's supplement submitted by Petitioner from July-October, 1982, was a supplement from Dr. Gould (RT 122-123). Also, Petitioner's counsel had told Financial that a Dr. Christensen was Petitioner's treating physician (Exhibit 36, pp.8-9, RT 104, 110-111). Financial had no physician's supplements from a Dr. Christensen. Finally, in his July, 1982 report, Dr. Miller had stated that Petitioner could return to work in a lesser capacity not involving stress (Exhibit 28). When Financial learned that a worker's compensation examination of Petitioner had been rescheduled in California for October 25th, they had decided to wait for the results of that examination before taking any action on Petitioner's file (RT 104-105). Although Petitioner was seriously deficient in furnishing attending physician's statements, Financial attempted to give Petitioner every opportunity to prove his continued disability (RT 104-105). When Petitioner failed to report for the October 25th examination, Financial determined that a review of his file was in order (RT 116-117, 162-163, 212). Petitioner's failure to appear at the Dr. Padova examination precipitated the review of his file, but was *not* the reason his disability benefits were discontinued (RT 116-117). Petitioner's employment was terminated because Petitioner did not respond to the

November 2, 1982 request to return to work (RT 226). Petitioner's employment was terminated under a Chrysler employment policy providing for termination of employees who are absent for work without having substantiated a valid disability and who refuse to return to work when requested (Exhibit 93; RT 226).

In the latter part of November, 1982, Financial received a letter dated November 15, 1982, from Petitioner's counsel requesting a review of the decision to discontinue disability payments (RT 129-130; Exhibit 38). Financial conducted a review of Petitioner's case and responded to counsel on January 15, 1983 (Exhibit 41). Counsel was advised of the reasons for the discontinuance of disability benefits, and was invited to supply additional medical information which would establish Petitioner's eligibility for continued benefits (RT 131). No such medical information or additional physicians' supplements were ever supplied.

On November 28, 1982, Petitioner applied for unemployment insurance benefits (Exhibit 201). His application was initially turned down by the Employment Development Department on the grounds that he had not proved that he had been released by his physician to return to work and it was therefore held that he was not available for work (Exhibit 202). Petitioner appealed this decision and certified to the Employment Development Department that he had been released by his physician and that he was actively seeking employment in the Las Vegas area. Petitioner attached a statement from Dr. Miller dated November 23, 1982, stating that he was able to return to work as of November 21, 1982 (Exhibit

203). In March, 1983, the decision of the Employment Development Department was reversed, a finding was made that Petitioner had been released by his treating physician and was able to return to work. Unemployment benefits were ordered paid to Petitioner (Exhibit 204). Petitioner testified that in November, 1982, he was able to perform some jobs of a non-stressful nature within his occupation (RT 302-304).

After filing suit in the United States District Court for the Central District of California, this case was tried by that Court, without a jury. At the conclusion of trial, the Court entered Findings of Fact and Conclusions of Law (CR 84; Appendix A), and a Judgment that Petitioner take nothing (CR 83; Appendix B).

Petitioner's case at trial centered upon two main contentions: (1) that Petitioner's benefits under DAP and LTD had been wrongfully discontinued; and (2) that Petitioner's termination of employment with Credit constituted "wrongful termination of employment" under California law. The Trial Court heard testimony from Mr. Jones, Credit's Long Beach branch manager during the 2½ months Petitioner was at the Long Beach branch; from Mr. McCarter and Mr. Slywka, employees of Financial and Administrators of DAP; from Mr. Culton, an employee of Financial and Director of Administration; from Petitioner and his wife; from Mr. John Stonewall Miller, Jr., an expert called by Petitioner as to ERISA matters; and Dr. James Padova, an expert called by Respondents as to Petitioner's medical condition.

The Trial Court found that the actions of the plan administrators, Mr. McCarter and Mr. Slywka, were not

arbitrary or capricious and did not reflect bad faith. Findings of Fact 12-46 set forth the Trial Court's findings of fact relating to the termination of benefits issue (Appendix A, pp. 3-7).

The Trial Court also found that Petitioner's employment had not been wrongfully terminated. The Court found that Chrysler's employment policies were reasonable and were followed by Credit in terminating Petitioner's employment. The Trial Court found that it was Petitioner who had acted unreasonably and had frustrated Credit's efforts to counsel Petitioner on his job status. Findings of Fact 31-37, 39-41 and 51 set forth the Court's findings of fact relating to the wrongful termination of employment issue (Appendix A, pp. 5-7).

Petitioner timely appealed the Judgment to the United States Court of Appeals for the Ninth Circuit based upon issues of whether the ruling was based on substantial evidence, and whether the Trial Court applied the correct law to the facts of the case (Appellant's Brief, pp. 1-2).

Petitioner attacked the Trial Court's decision based only upon its Memorandum of Intended Opinion, rather than on the controlling and clearly stated Findings of Fact and Conclusions of Law, (Appellees' Brief, pp. 10-11; Appendix A). Furthermore, Petitioner failed to cite any case or other authority for a standard of law relating to actions of ERISA plan fiduciaries in denying plan benefits other than the "arbitrary, capricious, or bad faith" standard stated in the Trial Court's Conclusion of Law No. 2 (Appellees' Brief, pp. 12-13). Rather, Petitioner appeared to rely on an attempt to re-argue the facts *de*

novo, instead of the accepted "clearly erroneous" standard of review (Appellees' Brief, pp. 9-10).

The Ninth Circuit Court of Appeals, in its unpublished Memorandum Opinion filed September 24, 1987, held that none of the District Court's findings with respect to the claim for disability benefits was clearly erroneous, and that Respondents did not act arbitrarily or capriciously in discontinuing Petitioner's plan benefits (Appendix to Petition, p. I-62). The Court also held that the Trial Court's finding that Petitioner was terminated because of his failure to report to work upon his employer's demand was not clearly erroneous, and that Petitioner was not wrongfully terminated for attempting to exercise rights under the disability plans (Appendix to Petition, p. I-63). As noted in Petitioner's Petition for Writ of Certiorari, the Ninth Circuit Court of Appeals' Memorandum does *not* address any alleged conflicts between the Summary Plan Description ("SPD") and the Plan itself with respect to 30-day reporting requirements under the Disability Absence Plan ("DAP") (Petition, p. 22).

SUMMARY OF ARGUMENT

Respondents respectfully submit that this Petition for Writ of Certiorari should be denied in its entirety, as Petitioner makes no showing that the decision of the Ninth Circuit Court of Appeals in this case in any way conflicts with any decision of another federal court of appeals on the same matter. Rather, Petitioner relies upon unstated inferences, contrary to clear Findings of Fact and Con-

clusions of Law entered by the Trial Court, and upheld by the Ninth Circuit, to allege that the terms of the SPD are inconsistent with the terms of the DAP Plan, which allegedly resulted in the discontinuance of Petitioner's benefits.

As no such inconsistency exists, as the courts below found, Respondents believe that the authorities and propositions which Petitioner cites are not applicable to nor dispositive of this case. Therefore, no basis for invoking the jurisdiction of this Court exists. Instead, Respondents contend that this Petition is merely another frivolous attempt by Petitioner to seek a *de novo* review of the facts by this Court, in hopes of obtaining a more favorable ruling.

Respondents limit this Brief to issues relating to jurisdiction of this Court to grant review by writ of certiorari, and respectfully reserve argument on the merits to a later time should the writ be granted.

———o———

ARGUMENT

I.

NO GROUNDS EXIST FOR GRANTING REVIEW BY WRIT OF CERTIORARI IN THIS CASE, AS THERE IS NO CONFLICT BETWEEN THE NINTH CIRCUIT'S OPINION IN THIS CASE AND DECISIONS RENDERED BY OTHER FEDERAL COURTS OF APPEALS ON THE SAME MATTER.

A. THERE IS NO JURISDICTIONAL BASIS FOR REVIEW

Rule 17 of the Court Rules of the Supreme Court of the United States, dealing with considerations governing review on certiorari, states, in pertinent part, that:

> 1. A review on writ of certiorari is not a matter of right, but of judicial discretion, and will be granted only when there are special and important reasons therefor. The following, while neither controlling nor fully measuring the Court's discretion, indicate the character of reasons that will be considered.
>
> > (a) When a federal court of appeals has rendered a decision in conflict with the decision of another federal court of appeals on the same matter; or has decided a federal question in a way in conflict with a state court of last resort; or has so far departed from the accepted and usual course of judicial proceedings, or so far sanctioned such a departure by a lower court, as to call for an exercise of this Court's power of supervision.

The timing for the filing of such review of a judgment or decree in a civil case is set forth in Supreme Court

Rule 20.2, which relies upon 28 U.S.C. Section 2101(c), which provides that:

> (c) Any other appeal or any writ of certiorari intended to bring any judgment or decree in a civil action, suit or proceeding before the Supreme Court for review shall be taken or applied for within ninety days after the entry of such judgment or decree. A justice of the Supreme Court, for good cause shown, may extend that time for applying for a writ of certiorari for a period not exceeding sixty days.

Supreme Court Rule 20.4 furthermore notes that this ninety-day period runs from the date of the denial of a timely filed petition for rehearing.

Petitioner does not specifically articulate the statutory or other basis upon which he seeks a grant of review by certiorari from this Court. Respondents can only infer then, from his argument in the Petition, that the above form that basis. Even should that be the case, Petitioner has made no adequate showing that the Ninth Circuit's unpublished opinion is in conflict with other courts of appeals.

This Court held in *N.L.R.B. v. Pittsburgh S.S. Co.*, 340 U.S. 498 (1951), that review by writ of certiorari will be granted only in cases involving principles, the settlement of which are important to the public, as distinguished from parties, and in cases where there is a real and embarrassing conflict of opinion and authority between courts of appeals. *Id.* at 502-03. *Cf. United States v. Constantine*, 296 U.S. 287, 290 (1935) (diverse decisions in district courts, pending cases awaiting settlement of issue presented, affecting large number of people).

In his own Petition, Petitioner variously admits that: "Neither the trial court nor the Ninth Circuit commented upon these and other contentions of Petitioner concerning violations of ERISA claims statutes and regulations." (Petition, p. 21); and that "In its Memorandum, the Ninth Circuit does not allude to the fact that there is not mentioned in the SPD any requirement of a 30-day reporting period to submit medical reports" (Petition, p. 22).

Notwithstanding these candid statements, which support Respondents' position rather than his own, Petitioner attempts to draw unsupported inferences that the Ninth Circuit opinion reaches its decision by tacitly allowing ERISA disability plan fiduciaries to rely on prescriptions *not* found in the SPD or the Plan in denying benefits to plan participants (Petition, pp. 22-23). After "bootstrapping" this erroneous conclusion, Petitioner then goes on to cite authorities from other federal courts which would conflict with such a result.

In fact, in correctly using the "clearly erroneous" standard of review, as set forth in Rule 52(a) of the Federal Rules of Civil Procedure, and as construed by this Court in *United States v. U.S. Gypsum Co.*, 333 U.S. 369, 395 (1948), the Ninth Circuit below held that there was substantial evidence to support the District Court's decision that the DAP required Petitioner to file attending physician's statements every thirty days, that he was timely notified of that requirement, and that he failed to provide that information as required (Appendix to Petition, p. I-61). Thus, in examining the record from the lower courts, and based upon the foregoing authorities, it appears clear that this case is not an appropriate one for

the exercise of this Court's discretion to grant review by writ of certiorari. Respondents respectfully request that the Petition be denied.

B. THE CASES PETITIONER CITES ARE INAPPOSITE

The case of *McKnight v. Southern Life and Health Ins. Co.*, 758 F.2d 1566 (11th Cir. 1985), cited by Petitioner, involved a situation where a former employee was denied credit under a pension plan for previous service. The SPD and the Plan in that case were consistent and mandated the same result in that employee's situation. *Id.* at 1569-71. The same situation exists in the case at bar. As both the District Court and the Ninth Circuit held below, the SPD and the Plan were consistent in requiring Petitioner to provide proof of continuing disability. This Petitioner failed to do, and benefits were thus correctly discontinued.

Petitioner's citation of *Morgan v. Mullins*, 643 F.2d 1320 (8th Cir. 1981), is likewise not dispositive of this case. There, the Trustees made an interpretation of a resolution which imposed additional signatory employment on a mineworker who was receiving Black Lung benefits before allowing pension eligibility. *Id.* at 1323-24. That case is factually distinguishable from the instant one, in that the Respondents' plan fiduciaries relied on the SPD and the Plan in requiring Petitioner to submit attending physician's statements every thirty days, consistent with their plain meaning.

Similarly, the decision in *Maness v. Williams*, 513 F.2d 1264 (8th Cir. 1975), fails to support Petitioner's contention of a conflict herein. In that case, a pension plan's

trustees disregarded the plain wording of the plan and settlement agreement to make a separate eligibility requirement superfluous by their interpretation. *Id.* at 1266-67. Again, as previously noted, the plan fiduciaries in the present case made no such inconsistent interpretation, but instead relied on the plain wording of the SPD and the Plan in discontinuing Petitioner's benefits.

The same result pertains in analyzing *Kochendorfer v. Rockdale Sash & Trim Co., Inc.*, 653 F. Supp. 612 (N.D.Ill. 1987). In the present case, the SPD is clearly identified as such, contrary to conflicting "record-keeping" and summary descriptions in the *Kochendorfer* case. *Id.* at 616. Furthermore, as distinguished from the facts of that case, the Respondents' plan fiduciaries made a decision based upon the plain words of the reporting requirements contained in the SPD and the Plan, of which Petitioner was notified (Appendix to Petition, p. 0-164, 0-165).

Likewise, the case of *Wilken v. AT&T Technologies, Inc.*, 632 F. Supp. 772 (E.D.Mo. 1984), *aff'd* 822 F.2d 1095 (8th Cir. 1987), while citing the accepted proposition that imposition of a standard not required by an ERISA plan can result in an arbitrary act by a plan trustee, does not apply, as no such external requirement was imposed in this case.

Finally, it is also interesting to note that the Ninth Circuit Court of Appeals, in its decision in *Turner v. Local Union No. 302, Int'l Bro'hd. of Teamsters*, 604 F.2d 1219, 1225 n.8, 1226 n.11 (1979), at least peripherally dealt with the issue of conflicting brochures and plans, and stated that Plaintiff in that action had shown no such conflict,

or reliance thereon, suggesting that there might have been a different result if that had been shown. *Id. (citing Hurd v. Hutnik,* 419 F. Supp. 630, 640 (D.N.J. 1976); *Gallo v. Howard Stores Corp.,* 145 F. Supp. 909 (D.C. Pa. 1956), *aff'd* 250 F.2d 37 (3d Cir. 1957)).

Thus, it again appears clear that the conflict claimed by Petitioner to exist between the reasoning of the Ninth Circuit and that of the Eighth and Eleventh Circuits, and other district courts, does not in fact exist. Based upon all of the foregoing, Respondents respectfully request that this Petition be denied.

II.

GRANT OF A WRIT OF CERTIORARI IS INAPPROPRIATE TO REVIEW FACTS OR INFERENCES THEREFROM.

This Court held in *General Talking Pictures Corp. v. Electric Co.,* 304 U.S. 175, 178-79 (1937), that granting of a writ of certiorari "would not be warranted merely to review the evidence or inferences from it. . . . Moreover, the decision on that point rests on concurrent findings. They are not to be disturbed unless plainly without support." *Id.* (citations omitted). *See also United States v. Johnson,* 268 U.S. 220, 227 (1925).

A reading of the "Questions Presented" in this Petition (Petition, p. i), as well as the remaining portions of Petitioner's Brief (Petition, pp. 29-42), reveals review of this case would depend upon yet another review of the facts contained in the trial record for what Petitioner hopes would be a more favorable ruling on the issues. As noted above, the Ninth Circuit found that the decision of the District Court in this case was supported by sub

stantial evidence, and that none of the operative findings or conclusions entered by that Court was clearly erroneous. (Appendix to Petition, p. I-62, I-63). Therefore, Respondents submit that further factual review of this case is inappropriate, and respectfully urge that this Petition be denied in its entirety.

CONCLUSION

The decision rendered by the Honorable David W. Williams, of the District Court for the Central District of California, in this case held that Petitioner was adequately and timely notified of the requirements of providing continuing proof of disability to Respondents under the terms of the Summary Plan Description and of its Disability Absence Plan. It was further concluded that Respondents did not act arbitrarily, capriciously, or in bad faith in discontinuing Petitioner's benefits under the Plan for failing to comply with its terms as specified. Finally, Judge Williams found that Petitioner was not wrongfully discharged, as his employment was not terminated for attempting to exercise ERISA rights; rather, he was discharged for failing to return to work upon Respondents' demand.

The Ninth Circuit Court of Appeals, by the Honorable Judges Beezer, Hall, and Hardy, upheld this decision on appeal, noting that none of the operative findings was clearly erroneous. The Ninth Circuit made no mention of the Respondents' plan fiduciaries imposing greater

reporting requirements upon Petitioner than those found either in the SPD or the Plan.

Yet, despite these facts, and, indeed, Petitioner's own admission of these facts within his Petition, he seeks to infer an erroneous, tacit conflict between the lower courts' decisions and those of other federal courts on the same matter. As shown above, no such conflict exists. The decisions Petitioner cites deal with cases either where an inconsistency exists between a Summary Plan Description and its underlying ERISA Plan, or where the plan fiduciaries have made an interpretation of their plan documents, contrary to their plain wording, which imposes greater or different requirements than stated. Neither is the case here. Respondents' plan fiduciaries decided to discontinue Petitioner's benefits based upon the consistent terms of the SPD and the Plan, of which Petitioner was adequately and timely notified. Likewise, Petitioner's exercise of ERISA rights was not the basis of his employment discharge.

Respondents respectfully submit that Petitioner is once again attempting to have this Court review factual issues, in hopes of a more favorable result. Such an attempt is not an appropriate one for an exercise of judicial discretion in granting review by writ of certiorari.

Based upon all of the foregoing Respondents respectfully request that the Court deny this Petition in its entirety.

DATED: April 11, 1988

Respectfully submitted,

IRSFELD, IRSFELD & YOUNGER

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Clerk, U.S. District Court
Central District of California]

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

JOSEPH M. LOESCHNIG, Plaintiff, v. CHRYSLER CREDIT CORPORATION, et al., Defendants.	CASE NO. 83 1350 DWW (JRx) FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The above entitled action came on for trial before the court, without a jury. Plaintiff appeared in person and by his attorneys, law offices of Steven Roseman, by Steven Roseman. Defendants appeared by Irsfeld, Irsfeld & Younger, by James J. Waldorf and Peter J. Irsfeld.

The court having considered the testimony, evidence and arguments of the parties, now makes and files the following findings of fact and conclusions of law.

FINDINGS OF FACTS

The court adopts the following findings of fact:

1. Defendant, Chrysler Financial Corporation, ("Financial") is a wholly owned subsidiary of Defendant, ChryslerCorporation [sic]. Defendant, Chrysler Credit Corporation ("Credit") is a wholly owned subsidiary of Financial.

2. Plaintiff was employed by Credit on February 8, 1967.

3. Plaintiff's job duties generally consisted of servicing delinquent accounts of automobile purchasers, repossessing automobiles when delinquencies became serious and negotiating financial transactions with franchise dealers.

4. Plaintiff was employed in the San Diego area at Credit's San Diego branch continuously from September 8, 1967 to approximately 1981.

5. In 1981, and at the request of Plaintiff, Plaintiff left the San Diego branch to go into a training program for the job of auditor.

6. After completing the training program, Plaintiff indicated to Credit that he wished another job assignment because the job of auditor required him to travel and disrupted his family life. He requested reassignment to his former job at the San Diego branch of Credit.

7. At the time of this request, Credit had no opening in its San Diego branch.

8. Plaintiff was permitted to join Credit's staff at its Long Beach branch and was assigned job duties of a lower level but with no reduction in salary. Plaintiff commenced work at the Long Beach branch on September 1, 1981.

9. Several years prior to 1981, Plaintiff had been diagnosed and treated by a Dr. Gould as having hypertension or high blood pressure.

10. Plaintiff's condition caused him to experience headaches and irritability.

11. In November, 1981, Plaintiff experienced an attack of dizziness while at home and requested his wife to drive him to a nearby hospital.

12. Plaintiff received treatment and was released after approximately one hour.

13. Plaintiff's wife telephoned the Long Beach branch of Credit and advised Credit that Plaintiff was not physically able to return to work.

14. Plaintiff's last day of work at Credit was November 18, 1981.

15. Defendant, Chrysler Corporation, maintains two disability plans for its employees. One plan is entitled "Disability Absence Plan" ("DAP") and is a 12-month plan. The second plan is entitled "Long Term Disability Plan" ("LTD"). Coverage under LTD commences upon expiration on [sic] the 12-month DAP coverage and is available for periods of extended disability.

16. DAP was administered by Financial for Credit's employees.

17. In November, 1981, Plaintiff applied for benefits under DAP, which benefits were granted.

18. Shortly after November, 1981, Plaintiff and his wife moved to Las Vegas, Nevada.

19. In January 8, 1982, the Company requested Plaintiff to submit to an examination by Dr. Russell Miller, a physician in Las Vegas.

20. On January 29, 1982, Dr. Miller confirmed that Plaintiff had disabling hypertension which was aggravated by the stress of his employment.

21. On July 22, 1982, Dr. Miller reported to Financial that Plaintiff could return to work but in a less stressful capacity.

22. During the 11 months subsequent to November, 1981, Financial set up three examination appointments for Plaintiff, two with the same doctor.

23. DAP required Plaintiff to submit attending physician's statements every 30 days as a condition to establishing his eligibility under DAP.

24. During the 11 months subsequent to November, 1981, Financial constantly urged Plaintiff to comply with his obligation to furnish attending physician supplements every 30 days to substantiate his eligibility to receive DAP benefits.

25. Plaintiff knew that DAP required him to furnish attending physician's statements every 30 days. With a

few exceptions, Plaintiff failed to comply with this requirement.

26. The policies adopted by Financial in requiring the submission of attending physician's statements at 30-day interval [sic] are reasonable.

27. Plaintiff felt he was burned-out. He wanted to get away from Chrysler and to block out of his mind any thought of his past association with Chrysler.

28. During the 11 months following November, 1981, Plaintiff did not contact any person connected with either Credit or Financial.

29. During the 11 months following November, 1981, representatives of Credit and Financial, on various occasions, attempted to contact Plaintiff. On each occasion, Plaintiff's wife would talk to said representatives but would refuse to summon her husband to the telephone. The reason given on each occasion was that he was under sedation and required bed rest.

30. Plaintiff enjoyed gambling and often spent 6 to 8 hours a day, 5 days a week playing poker in various Las Vegas casinos. Plaintiff also engaged in betting on sporting events. Plaintiff's gambling activities occurred continuously during the time Plaintiff lived in Las Vegas.

31. During the 11 months subsequent to November, 1981, Plaintiff moved his place of residence on several occasions. Plaintiff failed to advise either Financial or Credit of his change of address.

32. Financial experienced considerable difficulty contacting Plaintiff because of his failure to notify them of change [sic] addresses.

33. During the 11 months subsequent to November, 1981, Plaintiff followed a practice of avoiding any contact with Financial or Credit and successfully evaded any effort by Financial or Credit to personally contact him.

34. The practices followed by Financial and Credit to contact Plaintiff relative to his job situation and to administer DAP and LTD were not unreasonable and were not intended to upset Plaintiff or aggravate his condition.

35. Chrysler Corporation has a policy of actively discouraging workers to separate from their jobs.

36. Credit was willing to find a job for Plaintiff which would not aggravate his condition but was unable to communicate with Plaintiff to discuss the matter with him.

37. Plaintiff's practice of evading any contact with Credit or Financial frustrated efforts to counsel with Plaintiff relative to his job situation or the administration of his claims under DAP.

38. On November 2, 1982, Financial sent Plaintiff a letter discontinuing DAP benefits, effective October 25, 1982. The reason for such discontinuation of benefits was Plaintiff's failure to substantiate eligibility for DAP benefits.

39. The November 2, 1982 letter, described in finding 38 above, instructed Plaintiff to report to work at the Long Beach office of Credit on November 8, 1982.

40. Plaintiff failed to report to work on November 8, 1982.

41. On November 17, 1982, Financial sent Plaintiff a letter terminating Plaintiff's employment with Credit,

effective October 25, 1982. The reason for such termination of employment was Plaintiff's failure to report to work as instructed in the November 2, 1982 letter.

42. On November 15 and December 3, 1982, Plaintiff, through his counsel, wrote Chrysler Corporation appealing Financial's decision to terminate Plaintiff's DAP benefits. This appeal was forwarded to Financial for review and reply.

43. Financial did review Plaintiff's disability file and responded to Plaintiff's appeal on January 5, 1983.

44. The decision of the administrators of DAP to discontinue Plaintiff's benefits under DAP was not arbitrary or capricious and did not indicate bad faith on the part of said administrators.

45. The action of the administrators of the DAP in the review of Plaintiff's appeal was not arbitrary or capricious and the decision of the administrators not to reinstate DAP benefits did not indicate bad faith on the part of said administrators.

46. During his approximately 15 years of employment with Credit, Plaintiff did not receive assurances of continued employment by Chrysler Corporation, or its subsidiaries.

47. Plaintiff's employment was not terminated because of his failure to respond to a request for medical information. Plaintiff's employment was terminated because of his failure to report to work.

48. Plaintiff's employment was terminated under a policy of Chrysler Corporation relating to the discharge

of employees who failed to report to work or are absent from work without justifiable reason.

49. Financial and Credit complied with Chrysler Corporation policies and procedures in terminating Plaintiff's employment.

50. In terminating Plaintiff's employment, neither Financial and/or Credit acted in bad faith or with an intent to harm or injure Plaintiff or from any malice or ill-will toward Plaintiff.

51. The actions of Financial and Credit in terminating Plaintiff's employment were reasonable and justified under the circumstances of this case.

CONCLUSIONS OF LAW

1. DAP and LTD are covered by the provisions of the Employees Retirement Income Security Act of 1974 ("ERISA"). This conclusion of law is based upon this court's "Order Denying Plaintiff's Motion for Partial Summary Judgment" dated February 4, 1985.

2. The standard of review to be applied by this court in scrutinizing the actions of the administrators of DAP in discontinuing Plaintiff's benefits thereunder is whether such actions were arbitrary or capricious and reflected bad faith. *Hurn v. Retirement Trust Fund, etc., of Southern California*, 702 F.2d 386, 389 (9th Cir. 1983).

3. The requirement of DAP that attending physician supplements be submitted at 30-day intervals to establish eligibility under DAP is a reasonable requirement.

4. Plaintiff was timely notified of his obligation to submit attending physician's statements on 30-day intervals.

5. Plaintiff substantially failed to meet his obligation to provide medical information to the DAP administrators so as to substantiate his continued eligibility for DAP benefits.

6. The decision of the DAP administrators to discontinue Plaintiff's benefits thereunder was not arbitrary or capricious and said administrators did not act in bad faith.

7. The DAP administrators reviewed and responded to Plaintiff's appeal of his denial of DAP benefits in a timely manner and substantially complied with the requirements of ERISA relative thereto.

8. Plaintiff was not wrongfully denied benefits under DAP or LTD under the provisions of ERISA.

9. Plaintiff is not entitled to recover attorneys' fees under the provisions of ERISA.

10. Plaintiff's termination of employment was not wrongful and did not constitute the breach of any express or implied employment agreement between Plaintiff and Defendants and did not represent a breach of any covenant of good faith and fair dealing.

11. Defendants' conduct in terminating Plaintiff's employment was not willful, malicious or oppressive.

12. Plaintiff is not entitled to recover any damages from Defendants on account of the termination of Plaintiff's employment.

13. Defendants are the prevailing parties in this action and are entitled to recover their costs.

Judgment entered for Plaintiff [sic] in accordance with the above findings and conclusions.

DATED: June 3, 1986

/s/ DAVID W. WILLIAMS
UNITED STATES DISTRICT
JUDGE

"APPENDIX B"

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[3:30 p.m.
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Clerk, U.S. District Court
Central District of California
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Central District of California]
[ENTERED
June 6, 1986
Clerk, U.S. District Court
Central District of California]

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

JOSEPH M. LOESCHNIG, Plaintiff,	)	
v.	)	CASE NO. 83 1350 DWW (JRx)
CHRYSLER CREDIT CORPORATION, et al., Defendants.	)	JUDGMENT

This action came on for trial before the court, the Honorable David W. Williams, District Judge, presiding, and the issues having been duly tried and a decision having been duly rendered.

IT IS ORDERED AND ADJUDGED

That Plaintiff take nothing, that the action be dismissed on the merits, and that Defendants, Chrysler Cor-

poration, Chrysler Credit Corporation and Chrysler Financial Corporation recover of Plaintiff their costs incurred in this action and taxed at $_____.

Dated at Los Angeles, California this 3rd day of June, 1986.

/s/ DAVID W. WILLIAMS
JUDGE